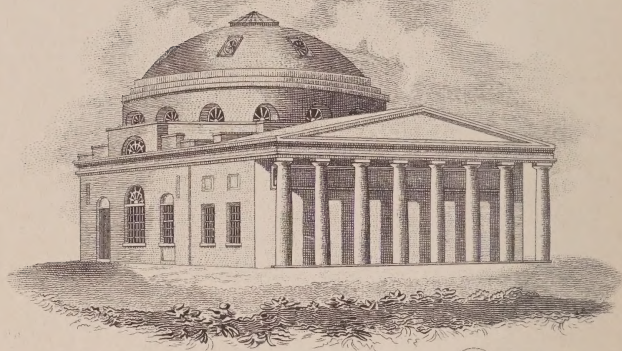
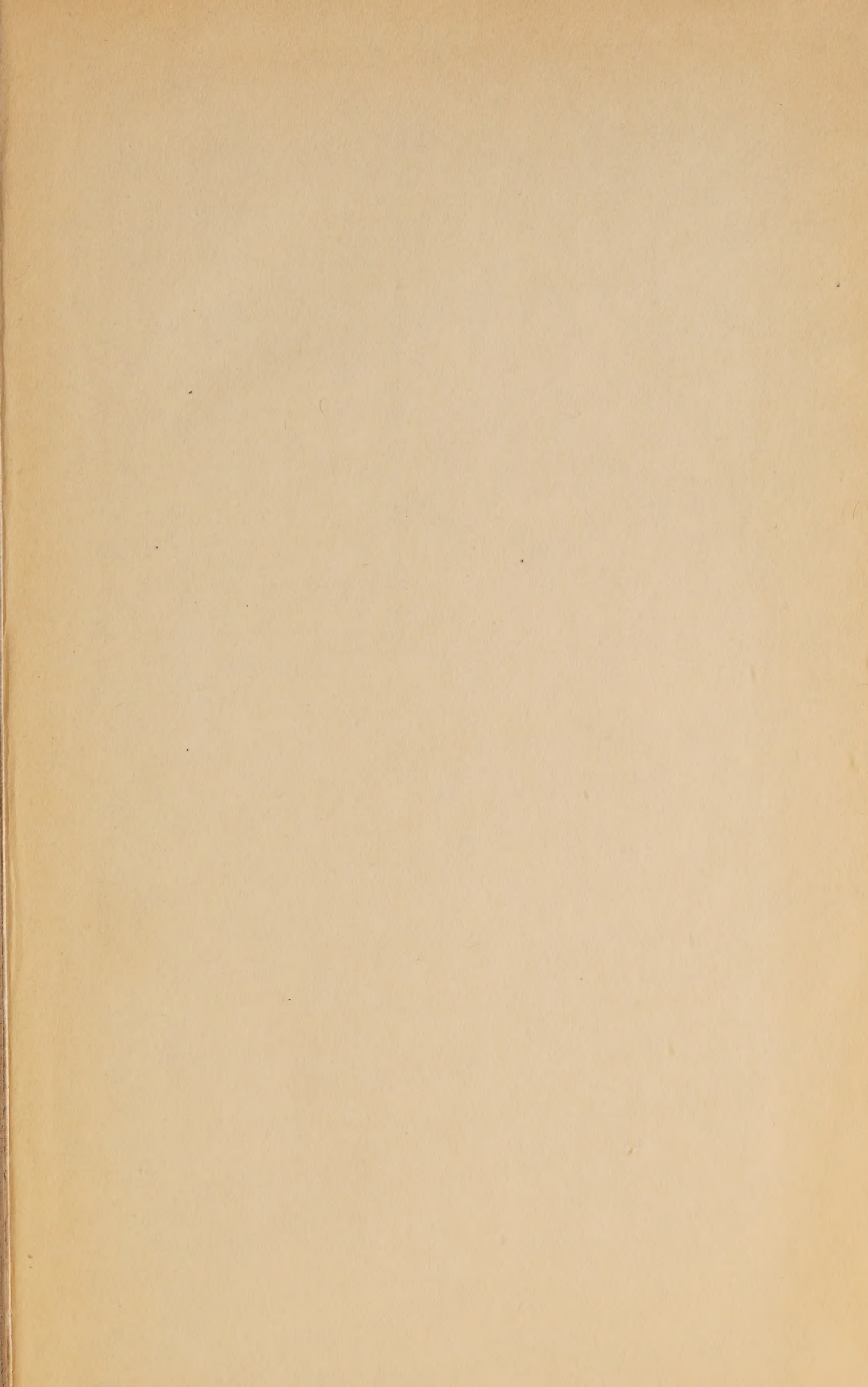
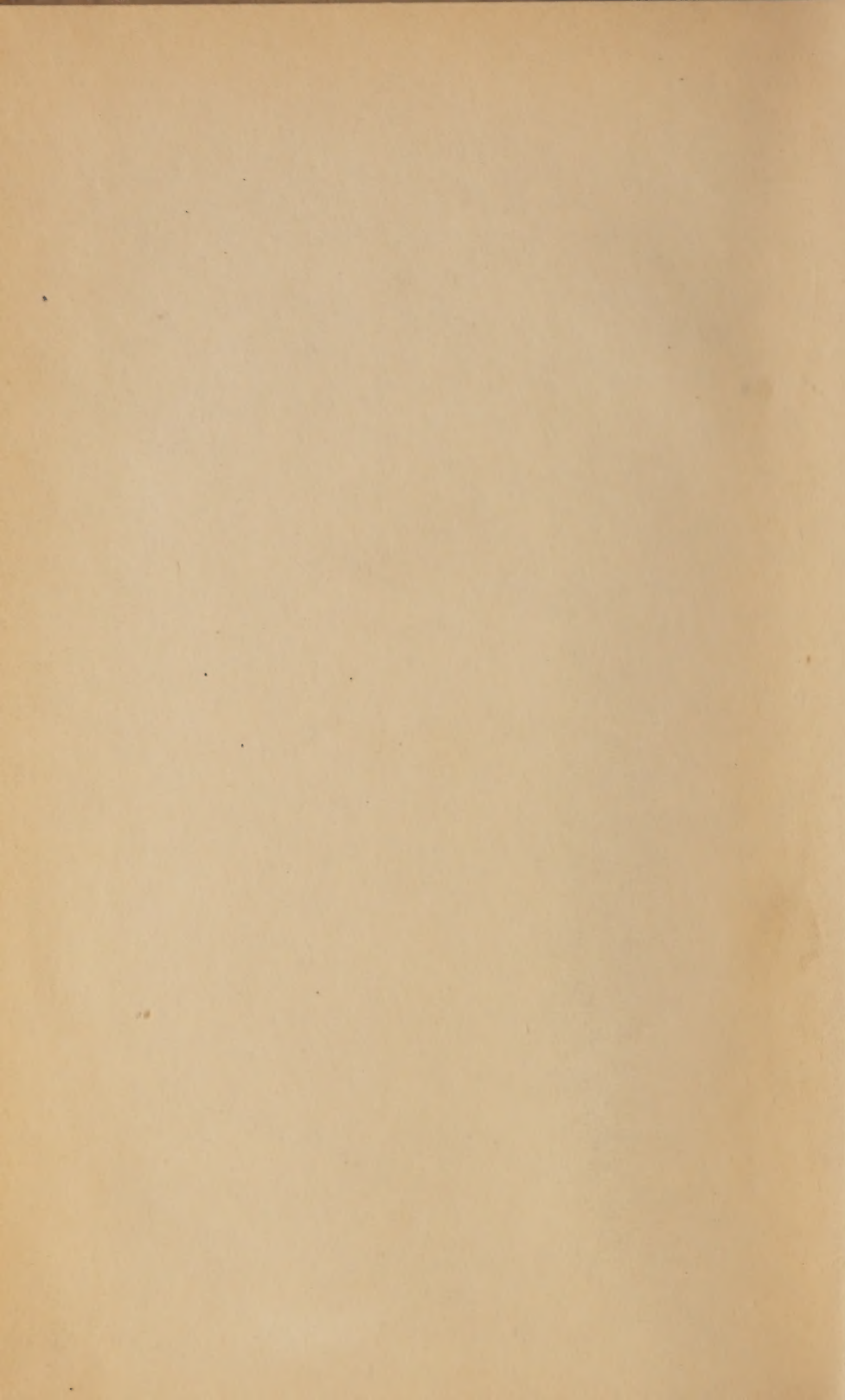


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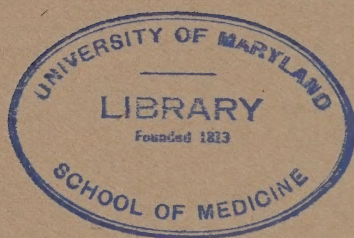
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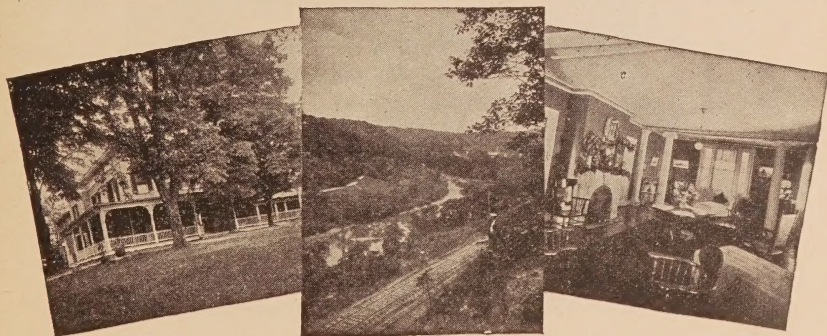
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PERSONAL REMINISCENCES OF THOMAS SARGENT
LATIMER, M. D.

Thomas Sargent Latimer was born in Savannah, Georgia, June 17, 1839. After his father's death the family changed their place of residence from Savannah to the little town of Shrewsbury, in southern Pennsylvania. And so it came about that young Latimer received his earlier education at the Sherwood Academy, in the neighboring town of York.

When eighteen years of age, having decided to study medicine, he came to Baltimore, and entered the Medical Department of the University of Maryland. For a time he was a private pupil of the distinguished Dr. Charles Frick, and, after Dr. Frick's death, he pursued his studies in the office and under the supervision of Dr. George W. Miltenberger.

In the spring of 1861 he received the degree of M. D. from the University of Maryland. These were troublous times. "The war between the States" was about to begin, and young Latimer, whose sympathies were strongly on the side of the South, was only too ready to support his convictions by deeds, and, so, shortly after his graduation, in May, 1861, we find him hurrying to Virginia to cast his lot with what was to become eventually the "Lost Cause." He enlisted at once, as a private, in the 1st Maryland Regiment, and soon afterwards took part in the great battle of Manassas. Not long after this he contracted typhoid fever, which came near ending his career.

In the fall of 1861 he was appointed assistant surgeon of the regiment which he had modestly joined as a private, and some months later he was made chief surgeon of this command. Subsequently he was placed in

charge of one of the military hospitals in Richmond, and at the time of Lee's surrender he was on special duty at Charlotte, North Carolina.

It was characteristic of the man, of his indomitable pluck and his tenacity of purpose, that even this momentous event did not lead him to feel that it was time to give up the fight. On the contrary, hoping that the war might be prolonged in the region west of the Mississippi River, he, with a companion, started out to tramp all the way from North Carolina to what was then known as the Trans-Mississippi Department. However, the two had not gone far on their wearisome journey when they learned of the surrender of General "Joe" Johnston and his army, and as this meant that further resistance was impossible, they concluded to surrender.

Shortly after this Dr. Latimer went to Porto Rico, where he spent some months with a brother who had taken up his residence there. He then returned to Baltimore, and in 1866 received the appointment of resident physician to the Baltimore Infirmary (now the University Hospital), which position he held until 1868. During his residence in the hospital he contracted typhus fever, which was epidemic for a time in the institution and carried off several members of the medical staff.

After leaving the Infirmary he began the practice of medicine in conjunction with Dr. Edward Lloyd Howard, and in 1870-71 he and Dr. Howard edited the "Baltimore Medical Journal." Subsequently he edited "The Physician and Surgeon."

In 1873 Dr. Latimer was appointed Professor of Histology and Pathological Anatomy in the College of Physicians and Surgeons and of Anatomy in the Baltimore College of Dental Surgery. His connection with these two institutions, in whose welfare he took a deep interest, continued up to the time of his death. In the former institution he held the chair of surgery from 1873 to 1876 and the chairs of physiology and diseases of children from 1876 to 1888, when he was made Professor of Medicine.

The high esteem in which he was held by his professional confrères was evidenced by the many positions of honor which they conferred upon him. In 1872 he was made President of the Baltimore Medical Association; in 1880 President of the Clinical Society of Maryland; in 1882 Vice-President, and in 1884 President of the Medical and Chi-

urgical Faculty of Maryland. In 1873 he delivered the annual oration before the Faculty, his subject being "Anæsthetics in Midwifery." His presidential address, in 1884, was a scholarly thesis upon the "Origin and Diffusion of Cholera." He was also a member of the Lunacy Commission of Maryland and for a time attending physician to the Nursery and Child's Hospital.

He had been in failing health for some months before his death, and, as might have been expected of him, as soon as he realized that he could no longer fulfill his professional duties in a manner satisfactory to himself, he pressed his resignation upon the Faculty of the College of Physicians and Surgeons. But of this his fellow members of the teaching staff would not hear.

He died at his residence on Monument street, surrounded by members of his family, on May 16, 1906, in his 68th year.

It was my privilege to have been thrown intimately with Dr. Latimer for many years before his death, and it may be said, without fear of contradiction, that those who knew him most intimately loved him best and held him in highest esteem. It is not an easy task to do justice to his character, in which were combined traits that are not often found linked together. On the one hand, he was as gentle, as kind-hearted, as unselfish, as considerate of others as the ideal woman. On the other hand he possessed the moral and physical courage, the high sense of honor, the tenacity of purpose, and, when a question of principle was involved, the uncompromising spirit of the ideal man; and withal he was generous to a fault.

His gentler characteristics are not inaptly portrayed in the slightly paraphrased lines of Lowell's:

He did those little kindnesses,
Which most leave undone, or despise;
For naught that sets one heart at ease,
And giveth happiness or peace,
Was low-esteemed in his eyes.

Gentle he was: God made him so:
And deeds of week-day holiness
Fell from him noiseless as the snow;
Nor did he ever chance to know
That aught were easier than to bless.

Although he was fond of outdoor life and was a keen sportsman, both with rod and gun, his tastes were distinctly literary, and he was a constant reader, not only of medical but of general literature. Particularly was he devoted to Shakespeare and to poetry of the better sort, and he was never at a loss for an apt quotation. He was, without exception, the most insatiable novel reader I have ever known.

Dr. Latimer was not a religious man, as the term is commonly understood. The dogmas of the theologians and the doctrines of the schoolmen were to him matters of little concern; and it is quite certain had any one smitten him upon the right cheek he would not have turned the left for like treatment. And yet he was, in the best sense of the word, truly religious; for he was the very embodiment of the ethical precepts that dignify the greater religions of the world and make them worthy of respect.

What many do, lest they should miss
The guerdon of eternal bliss,
He did, without such hope in sight,
From hate of wrong, from love of right.

CARE OF THE INJURED.

By DR. ARCHIBALD C. HARRISON.

The proper care of the injured should begin, of course, at the time of injury, but most severe injuries are received under conditions amid such surroundings as to make anything like ideal care impossible. As a matter of fact, many cases receive treatment which is most undesirable. Though all manner of effort has been made to instruct the layman in the more simple modes of handling the injured, I have not been able to observe that much has been accomplished in this direction, save in a negative way. Indeed it is surprising to note how often the inexperienced physician fails to appreciate the most essential principles of early aid to the injured.

As a rule we have had no part in the management of these cases until they reach the hospital, and, therefore, we begin our consideration at the time of reception into the accident department.

We cannot go into all the details of handling these cases, as much of it is rather primitive in nature, but it may be worth while to consider

very briefly: I, shock; II, the operation; III, preservation of parts; IV, amputation.

Shock has to do with the individual from the moment of the accident until he has safely reacted after all surgical procedures are finished. Therefore, to properly appreciate the conditions with which we must deal after the patient is in the hospital, we must take into consideration what he has sustained prior to this time. Many minor details have a bearing on the subject, but we can consider only the graver ones.

Severe injuries are usually received under conditions which are most alarming, and especially is this true of railroad injuries. The psychic influence is a tremendous element in the production of shock. Add to this primary psychic shock the long exposure to cold; being carted a variable distance and landed in a hospital amid strange physicians, about whose ability he knows but little and whose personal interest, in himself, he believes to be honored principally in the breach, and we have a series of events which, I think, is calculated to produce a degree of psychic shock second only, if at all, to that which is produced by trauma or what is known as mechanical shock. This psychic or nervous shock is a well-known phenomenon and said to be due to the powerful impulses from the highly specialized centers of the cerebrum acting upon the vital centers of the medulla. Be this as it may, it seems certain that impulses of this nature produce results more or less identical with surgical shock produced by mechanical injury. Indeed, it is impossible to differentiate between prostration by fear and prostration by injury, the former being often the more lasting impression. If it be granted, then, that this psychic influence is as potent as I have depicted and believe it to be, we will have four major elements with which to deal in combating the condition of shock as we find it: First, the psychic influence; second, mechanical irritation; third, loss of blood, and, fourth, depression of body heat. The sum total of the action of these elements will be expressed in the depression of the vital forces to the various degrees of shock which may be observed.

In our handling of the case we cannot take up each part in sequence because many things must be worked along together. The staunching of severe bleeding is, of course, the first necessity and must be seen to at once. Next, and of prime importance, is to render the individual comfortable, both mentally and physically, in other words, to obtain the

greatest degree of physiological rest possible. This is, of course, a large problem and often hard to solve, but much may be accomplished by kind and gentle treatment, calming the patient's fears and excitement and substituting therefor the element of hope to the largest degree possible. In other words the surgeon, assistants, and attendants should so conduct themselves as to inspire the patient's confidence in those who have him in charge. These are the chief means, save possibly one, of combating the psychic element in shock and if they can be brought about much has been accomplished, and they should be striven for with just as much earnestness as any other part of the treatment.

Mechanical, traumatic, or irritation shock is that which is produced by the injury to the peripheral nerve and probably acts by rapid exhaustion of the vital centers due to excessive stimulation. To combat this element sufficient morphine should be given hypodermatically to relieve pain, and here two things are accomplished, each most desirable, the relief of bodily pain and mental anxiety, both of which are potent elements not only in the production, but in the maintenance of depression. If a member be attached by a bit of skin, large nerves and tendons, as is often the case, these should be clipped with scissors and the part removed, thus getting rid of a certain amount of irritation from dragging on the nerves. The injured part should be wrapped in sterile gauze, covered heavily with cotton, splinted, and firmly bandaged to await the operation proper. If the condition be thought too grave to permit of immediate operation, tourniquets should be removed and direct clamping of the large vessels applied, provided that does not involve too much of an operation in itself.

From the moment the patient is received every arrangement should be made for keeping him warm, nothing is more important than raising the depressed body heat by the application of blankets and artificial heat, by every means possible within the range of safety against burning. This should be seen to with the greatest care until the patient is safely over his shock, before, during, and after operation. Then comes the question of stimulants, and on this point there is the greatest diversity of opinion. Strychnine, whiskey, nitroglycerine, adrenaline chloride, normal salt solution, and coffee are the ones most in vogue.

I am not ready to discard strychnine entirely, but believe its greatest good, in shock, is produced by moderate doses, say, a single injection of 1/30 grain, to be followed by doses of 1/60 grain at intervals of three to four hours. I am satisfied the large amounts frequently given are at least useless and may be potent for harm.

Whiskey is on the border line and is of doubtful value. If given by mouth, it should not exceed 1 to 2 ounces, well diluted with hot water. Its best use is as an adjunct to enemas of hot coffee or hot salt solution. Its effect for good is chiefly due to its analgesic action and its well-known power to dispel mental perturbation, but in these latter respects it is far inferior to morphia.¹

Nitroglycerine is worth giving in the early stages of shock, but its action is very evanescent and serves but small purpose. Adrenaline is also fleeting in action, but may serve a good purpose in extreme degrees of depression. Not more than 10 to 20 m should be given. It is possible that some sustained action may be obtained by adding 15 to 30 m to 500 cc. of normal salt solution and injecting this slowly under the skin. Strong solutions of coffee or tea seem to possess considerable value given in full quantities, both per orem and per rectum. They at least offer a means of introducing considerable quantities of heat into the central cavities of the body, a procedure most valuable.

Salt solution is of great value, but finds its chief efficacy in those cases in which the loss of blood is a prominent feature. Here 500 to 1500 cc. may be run under the skin, according to the estimated proportion of blood that has been lost. In the cases that have not lost much blood its value is less clear, and here not more than 500 cc. should be given. In any event it offers another means of introducing heat into the body. The chief means then of combating the condition of shock are: Control of hemorrhage, removal of sources of irritation, relief of pain and mental anxiety, and raising the body temperature by every means possible, within the range of safety.

When shall the major operation be performed? Where the degree of shock is grave and the contemplated operation extensive, I know of no way of reducing this perplexing problem to anything like a working

¹ Herein lies the explanation of the drunkard's immunity against shock, the psychic element being obtunded.

formula. To judge wisely is difficult and depends principally upon one's ability to estimate with some degree of accuracy what amount of additional traumatic insult the patient will withstand.

The operative technique requires the consideration of many details, but the chief features are to obtain an aseptic field and to reduce the anæsthetic and manipulation time to the shortest space compatible with thorough work. Ordinarily these cases require comparatively little anæsthetic and by arranging the various steps of the procedure so as to use it only during the time of need, it can be much reduced. These cases come to us with all manner of greasy dirt ground into their wounds, which may be of such number and extent that the mere multiplicity of wounds to be repaired make the consumption of much time unavoidable. The preparation of the various operation fields is often the chief part of the procedure and when properly done the wound will follow an aseptic course as a rule. Indeed the point of remark is not that we sometimes fail to get aseptic wounds, but how uniformly we succeed.

The question of whether to amputate or not to amputate is often a most perplexing one and may be treated under "Indications for primary amputation." These have been entirely recast in the past two decades and in every case, where the indications are not absolutely clear, the patient should receive the benefit of the doubt. To judge well the indications in a given case implies a comprehensive and accurate knowledge of the nature and extent of the injury, and a fairly accurate knowledge of anatomic detail is of great advantage in determining these points.

Extensive crushing of a part with definite injury of the large vessels and nerves is the chief factor in favor of amputation, but extensive decoration with or without grave crushing of the bones, vessels, etc., may sometimes demand amputation. Granting that amputation must be done, it is of prime importance where? In the upper extremity it still holds good that every fractional part should be saved that can be. In the lower extremity, however, a modern amputation should have in view not only the removal of dead tissue—sources of infection that threaten life and are beyond the reach of more conservative treatment, but also the securing of a painless stump suitable for the application of an artificial leg. The pathological demands are often at variance with the prosthesis, as is best illustrated with amputations through the tarsus and

about the ankle joint, *e. g.*, Lisfranc's, Chopart's, Syme's Perogoff's, etc. These seldom give good stumps and make it next to impossible to fit any satisfactory prosthetic apparatus. If one must go above the tarso-metatarsal joint the only good place is anywhere in the middle third of the leg. Even for the poor, who must be content with a peg leg, this is still the most desirable point.

GOITRE.

A STUDY OF ENLARGEMENTS OF THE THYROID GLAND.

By DR. ALEXIUS McGLANNAN, '95.

Among the laity goitre is a term for any swelling of the thyroid gland. In medicine its use should be restricted to the hypertrophies of the thyroid as distinguished from tumors and inflammations.

During early embryonic life the thyroid gland consists of acini lined by epithelium, many of them packed with cells, contained in a scanty fibrous stroma. The gland is surrounded by a dense fibrous tissue capsule. The blood vessels and lymphatics run in the stroma. On section this fetal thyroid is smooth and homogeneous. As development proceeds the colloid material is formed in the alveoli so that at birth the gland is made up of vesicles filled with colloid lined by a single layer of epithelium. The colloid vesicles vary in size, and here and there among them one sees areas of young thyroid where the alveoli approach the fetal. The stroma remains scanty and very vascular. The blood vessels are thin walled.

The cut surface of the normal thyroid is spongy, red in color, with glistening gelatinous areas of colloid varying in size from pin-point to pin-head or larger.

The epithelium of the thyroid secretes material of tremendous importance in metabolism. When the thyroid gland is completely removed by surgical operation or its epithelium destroyed by disease there develops a series of changes called myxedema.

In myxedema there is a marked increase in the bulk of the body. The skin and subcutaneous tissues are thickened by an inelastic swelling, with local tumefaction. The nutrition of the skin and hair is disturbed. Thought and action are strikingly slow. The mental faculties are dulled. There is remarkable alteration of the physiognomy, with great coarseness

of the features. *Cretinism* is congenital myxedema, and *cachexia strumipriva* is the myxedema following operative removal of the thyroid.

THYROIDISM is the condition resulting from an excess of the specific secretion of the gland. The symptoms of thyroidism are restlessness, tachycardia, tremor, irritation of the skin, and occasionally gastro-intestinal disturbance. When severe, thyroidism causes delirium, convulsions, with high fever, coma, and death.

Thyroid swellings are distinguished from other lumps in the neck by their position below the larynx, behind the sterno-mastoid, sterno-hyoid, and sterno-thyroid muscles, and in front of the carotid artery. The clinical symptoms of the various swellings are due to pressure, or to alterations in the secretion of the gland, occasionally to a combination of both.

Enlargements of the thyroid are classified into three groups: I, hypertrophies; II, tumors; III, inflammations.¹ The hypertrophies are always symmetrical enlargements, that is, both lobes of the gland are swollen. The tumors are asymmetrical swellings, most often they are unilateral. Inflammations usually form symmetrical enlargements, but may be unilateral.

HYPERTROPHIES.—There is a normal enlargement of the thyroid at puberty and often during menstruation and pregnancy. Disregarding this condition, the hypertrophies are of two kinds: (a) Simple Goitre, (b) Exophthalmic Goitre.

(a) SIMPLE GOITRE forms an elastic symmetrical swelling, usually giving only pressure symptoms, but occasionally, especially in old cases, giving symptoms of myxedema because of the destruction of epithelial cells.

This goitre is made up of greatly distended colloid vesicles, with hypertrophied fibrous stroma. The colloid of some of the vesicles is occasionally hemorrhagic. In places the epithelium is degenerated, converting the vesicle into a colloid cyst with a fibrous wall.

The cut surface has a characteristic mosaic appearance. The large vesicles glisten with colloid, showing a beautiful fluorescence, while the hemorrhagic vesicles here and there are dark red. Hypertrophied stroma sharply defines the borders of the colloid areas.

(b) EXOPHTHALMIC GOITRE forms a rather firm swelling of the gland,

usually one lobe is more distinctly hypertrophied, occasionally the swelling is most prominent in the isthmus. The swelling in the neck is associated with marked general symptoms. Three of these, exophthalmus, tachycardia, and tremor are characteristic of the disease when associated with enlarged thyroid.

Exophthalmus. The eyes are prominent to bulging—this condition gives the disease its name. The degree of exophthalmus varies greatly, and may be unilateral. The lids do not completely cover the sclerotics. The upper lid does not follow a downward excursion of the eyeball. Visual disturbance is rare.

Tachycardia. Early in the disease and in mild cases the pulse rate may be about 100, but as the disease progresses a rate of 150 or 160 or over is usual. The heart's action is extremely forcible and is regular except late in fatal cases. Visible capillary pulsation is common. Heart murmurs and bruits may be heard.

The heart is always irritable in this disease, and there gradually develops a condition of cardio-vascular weakness, with diminished blood pressure, called by Kocher² the *goitre-heart*.

Tremor. The fine tremor is involuntary. This symptom is present in the early cases and is of great value in diagnosis.

Associated with the four cardinal symptoms various other symptoms occur, gastro-intestinal disturbance, skin lesions, urticaria, pigmentation, leucoderma. Mental disturbance, with a tendency to irritability and depression often occurs.

There is a form in which the thyroidism becomes fulminating, death occurring in 24 to 72 hours. In these patients there is fever and delirium, very rapid heart action, frequently convulsions, ending in death in coma. Acute mania is a serious complication, terminating fatally in 2 or 3 days.

The change in the thyroid in the disease exophthalmic goitre is a definite hypertrophy of the epithelium, and the pathological picture is called exophthalmic hypertrophy.

In well developed exophthalmic goitre the hypertrophied thyroid on section presents a meaty appearance similar to cut muscle, showing very little colloid. In early cases there are large areas of unaltered thyroid, so that the gland will show more or less colloid according to the degree of the hypertrophy. Very early in the disease there may be only focal areas of hypertrophy.

Microscopically the alteration in the form of the vesicle is striking. The wall becomes involuted, affording greater surface for attachment of the epithelium, which changes from the resting to the active or higher type. As these papillomatous ingrowths invade the acinus, the colloid gradually disappears.

These changes are identical with those described by Halsted³ in his experimental hypertrophy of the thyroid. A study of his descriptions will give the best possible idea of exophthalmic hypertrophy.

Struma Recidiva (Kocher) is the recurrence of symptoms of exophthalmic goitre after operation. In all cases it has been found that too small a portion of the thyroid was removed at the operation. The condition requires a second operation, removing more of the gland. Recurrences after operation are becoming rarer, because at present it is the rule to remove the major portion of the thyroid at the first operation.

In performing the extensive primary operations and the operations for recurrence great care must be taken to leave at least two parathyroids. Removal of all four parathyroids causes tetany. These minute bodies are situated unequally in relation to the thyroid, but are almost always near the superior and inferior arteries.

The search for a specific animal remedy for exophthalmic goitre is stimulated by the brilliant results of thyroid extract treatment in myxedema, but as yet operation is the only satisfactory treatment of exophthalmic goitre. Rest in bed, with cold applications to the gland, galvanism, and the internal administration of belladonna and of digitalis are the usual medical measures employed. This treatment will relieve or abate some of the symptoms. Rest in bed is the most valuable of these measures and should always precede operation.

The specific serum⁷ made by inoculation of an animal with pieces of exophthalmic goitre obtained by operation is said to have some value in treating the disease. The dried blood (thyroidectum), and the milk of animals from whom the thyroid has been removed, have been tried and found useless.

TUMORS of the thyroid appear as asymmetrical enlargements of the gland, usually unilateral. Some are congenital, others occur at varying ages. Except for the congenital ones, tumors are rare before puberty.

Those occurring in people over thirty years of age are very likely to be malignant and for that reason demand immediate operation. Benign tumors may take on malignant change. The general symptoms of malignancy in a thyroid tumor are those of pressure, due to infiltration. A small asymmetrical swelling of the thyroid that does not move with attempts at swallowing, especially when associated with alteration in the voice and dyspnoea, is malignant. There may be cough with or without bloody expectoration. Unfortunately a tumor with such definite clinical symptoms is practically always beyond hope of cure by operation. The only safe rule is to remove all enlargements of the thyroid that appear after thirty.¹

THE BENIGN TUMORS OF THE THYROID are divided into cysts and adenomata. Of the latter two distinct types are recognized—the fetal and the colloid. Certain tumors combine some of the characteristics of the other varieties—the mixed adenomata.

CYSTS.—The cysts form smooth swellings, when superficial they are rounded, but when situated deep in the gland they seem to be flat. They may fluctuate, but usually are rather firm. Their size varies greatly without regard to their duration. An old cyst often shows alteration in size at various periods of its course. Usually they are single, but multiple cysts are not uncommon.

Cysts are the most common tumors occurring after the age of twenty-five. They are very rare before puberty, and do not seem to bear any relation to pregnancy, and are seldom met with in diseased thyroids. Trauma is not an etiological factor.

Occasionally a cyst is accompanied by atypical symptoms of thyroidism. These cysts are surrounded by an area of compressed thyroid tissue, showing areas very much like exophthalmic hypertrophy. The symptoms always disappear after removal of the cyst.

The cyst wall is connective tissue, sometimes laminated like the sack of an aneurism. The wall is surrounded by a layer of thyroid tissue which is compressed by the growth of the cyst, so that the colloid alveoli are altered in shape, some of them being involuted.

The cyst may extend until the entire lobe is replaced by the tumor. It is easy to imagine bilateral cysts of the thyroid of such size that the destruction of thyroid epithelium would be sufficiently extensive to give

symptoms of myxedema. When removing bilateral cysts at operation we must be careful to leave thyroid tissue. This will often require the evacuation of the contents of the cyst, and the dissection of the connective tissue wall from the thin layer of thyroid surrounding it.

Cysts with intracystic papillomatous growths are rare. The tumor is made up of many small cysts, with ingrowths covered by epithelium. These cysts are especially dangerous because with epithelial proliferation there is great probability of malignant change.

FETAL ADENOMA is usually a congenital tumor, or one occurring before puberty. Here the enlargement of the thyroid is firm and nodular. The tumor is an encapsulated area of fetal thyroid. On section we see the fibrous capsule separating the tumor from the normal gland, the surface is smooth, homogeneous and finely granular, without colloid.

COLLOID ADENOMA is an encapsulated area of simple goitre, and presents the same gross appearance.

As a rule the only symptom of either type of adenoma is the presence of the tumor, occasionally with some pressure symptoms.

MALIGNANT TUMORS OF THE THYROID may be either carcinoma or sarcoma. The age of onset is over 30, with both sexes equally liable to the disease. Fortunately these growths are rare, because all clinically malignant tumors of the thyroid have been hopelessly inoperable.

The general symptoms of malignancy, due to infiltration, have been mentioned. To emphasize its importance the rule is repeated here: *Every asymmetrical enlargement of the thyroid, occurring in an individual over 30 should be immediately removed by operation.*

CARCINOMA occurs most frequently between the ages of 40 and 60. The duration of life with clinically malignant growths has averaged about two years.

The tumor is hard and nodular, infiltrating the glandular tissue.

The infiltration usually extends at first in the direction of the trachea, and involves the recurrent laryngeal nerve. On section the tumor appears as a diffuse infiltration, showing yellow areas, surrounded by a red and grey zone. Small granular masses may be expressed from the mass.

Microscopically the vesicles show alteration of the epithelium. Instead of the normal lining of a single layer of epithelial cells, there is proliferation, with a piling up of the cells into the cavity of the vesicle, in some

places as papillary ingrowths, in others completely filling the cavity. In a few places there are solid collections of epithelial cells without any perceptible wall. Erhardt* considers this picture the earliest change in carcinoma of the thyroid. Definite infiltration of the stroma by epithelial cells and the formation of cancer nests occur later.

SARCOMA of the thyroid is extremely rare. The appearance of the infiltrating tumor is similar to sarcoma of other regions. Any variety of sarcoma may occur here, and the prognosis and duration of life will depend on the type of the tumor.

INFLAMMATION of the thyroid (thyroiditis) may be either acute or chronic. Except when the direct result of injury, the inflammation is always metastatic. Any of the acute infectious diseases may be complicated by thyroiditis. Tuberculosis and syphilis of the thyroid have never been described.

The inflammation may be parenchymatous or interstitial. In acute parenchymatous thyroiditis there is proliferation and desquamation of epithelium, so that microscopically the vesicles resemble those of exophthalmic goitre. Interstitial thyroiditis causes connective tissue proliferation with alteration of the circulation. The nutrition of the epithelium is thus disturbed with consequent loss of thyroid function. In the chronic inflammations this nutritional change is prominent and accompanies a hardening and shrinking of the gland.

The destruction or alteration of function of the epithelium leads to the development of myxedema. For this reason a swelling of the thyroid occurring in the course of an acute infectious fever, especially in pneumonia, influenza, and typhoid fever, should be noted and the patient carefully observed for symptoms of myxedema.

Suppurative inflammation occasionally occurs. The abscess is incised and drained. Simple inflammations are treated by rest in bed, ice bag to the gland, and general measures. With the onset of symptoms of myxedema thyroid extract should be administered.

OPERATIONS for the cure of diseases of the thyroid are: Removal of a portion of the gland for the hypertrophies; removal of tumors, and transplantation of a lobe of the thyroid from one individual to another for the myxedema.³

These operations are best described by Kocher.⁵ Kocher prefers

cocain because of the serious danger from pressure with general anæsthesia. On the other hand the Mayos⁶ use ether by the drop method, and have had no bad results from the anæsthetic. This is probably due to the skilful way in which the ether is given in their clinic.

The collar or transverse incision is made through the skin and platysma, extending from the outer border of our sterno-mastoid to the other, over the center of the swelling. If the mass is very large the lower flap is split by a second incision at right angles to this, extending to the sternum, if necessary.

The muscles covering the gland are retracted, or if sufficient space can not be obtained by this means, the sterno-hyoid and sterno-thyroid are divided close to their upper attachment. The gland is now dislocated by traction, when an entire lobe is to be removed, and the superior thyroid vessels ligated and divided. The inferior vessels are exposed on the deep muscles of the neck by drawing the gland over the trachea to the opposite side and are then ligated and divided. The recurrent laryngeal nerve ascends behind the inferior thyroid artery, and care must be taken to avoid injury to the nerve during the ligation. At the lower pole of the lobe, the thyroideæ imæ vessels are ligated and divided. Next the isthmus is divided. The communicating veins running across it are ligated separately. The isthmus is clamped with crushing forceps and the stump tied with a strong ligature. The isthmus being firmly attached to the trachea must be separated carefully to avoid wounding the latter. As a rule drainage of the wound is necessary. Exophthalmic goitre requires as free drainage as a septic wound. For other conditions a protective drain for 24 to 72 hours is sufficient.

The wound is closed by careful suturing in layers. If the s. hyoid and s. thyroid muscles have been cut, they are reunited. The divided platysma is brought together by a special suture, that prevents spreading of the scar. The skin is closed either by a subcutaneous continuous silver-wire, or by interrupted fine silk.

The important points in the operation are the control of hemorrhage and gentle handling of the gland. All vessels should be secured before division. Undue pressure on the gland must be avoided because acute thyroidism has followed rough manipulation.

When operating for recurrent exophthalmic goitre it is imperative that

the parathyroids be left undisturbed. This is accomplished by leaving thyroid tissue around the vessels. Cysts require careful dissection, leaving as far as possible all unchanged thyroid tissue. This becomes essential when operating for bilateral or recurrent cysts.

Solid tumors require the removal of the lobe in which they are situated.

Transplantation of a lobe of the thyroid from one individual to another has been performed for the cure of myxedema. The cut surface of parenchyma is everted, bringing the fibrous capsule inside. A pocket is made in the spleen, into which this lobe is inserted and retained by sutures.

It is interesting to note that this method of transplantation is available only between individuals who are blood-relations.

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GONORRHEAL URETHRITIS IN THE FEMALE.

By DR. A. SAMUELS, '98.

The term "urethritis" includes all forms of urethral inflammation. By far the most common of these inflammations is the gonorrheal. Cases of urethritis originating without the influence, direct or indirect, of the gonorrheal infection are rare. Other forms of urethritis arising from constitutional defects or from mechanical or chemical injury to the urethral membrane occur, but they are chiefly interesting from the standpoint of their etiology, since in symptoms and treatment they correspond with some of the stages of the more common disorder.

In the following pages the subject under consideration is gonorrheal urethritis in the female.

Formerly gonorrhea of the vagina ranked first in importance and frequency, but recent observations and studies have conclusively proven

that the virulent suppuration caused by the gonococcus is most frequently found in the urethra (Taylor). H. Kelly states: "All inflammations of the urethra not caused by a foreign body are due to the gonococcus."

The disease is more common between the ages of puberty and the menopause and rare in childhood and old age.

Chronic urethritis is the lesion most frequently seen. The doctor in many instances is responsible for this condition of affairs. Cases of gonorrheal urethritis are diagnosed symptomatically as "Cold on the bladder," "Cystitis," or "Irritation of the bladder." A coexisting vulvitis is frequently diagnosed as leucorrhea. In a large number of cases the treatment is worse than the diagnosis.

Noeggrath made extensive observations in New York and stated, "That 80 per cent of married men have had gonorrhea and that 90 per cent of these have never been thoroughly healed, and that of five married women three have gonorrheal urethritis" (acute or chronic.)

Zweifel and Sanger find 18 per cent of women with gonorrheal urethritis.

In 353 cases of gonorrheal infection Laser found the gonococcus in the urethra 111 times; 7 times in the vagina in 180 cases. In four-fifths of the 111 cases of urethral infection there were no macroscopical evidences of a urethritis.

Palmer Dudley has frequently demonstrated the gonococcus in the urethra where there were no visible secretions.

B. Tarnowski, in 750 cases, found acute and chronic urethritis in 268 cases. Steinschneider, in a study as to the localization of the gonorrheal infection, in 34 cases (Fresh), found the gonococci in the urethra in them all. Flora Pollack examined 1098 cases in the Woman's Venereal Department at the Johns Hopkins Dispensary, both subjectively and bacteriologically for the gonococcus, it was found that out of 668 cases, 466, or 68 per cent, had urethritis; 173, or 25 per cent, had no symptoms.

Two hundred cases from private practice and the Woman's Department at the City Hospital Dispensary, 120, or 60 per cent, was found to have been infected with the gonococcus. Of these cases all had acute or chronic urethritis. Three per cent of these cases were in prostitutes.

In Pollack's series of 515 cases of urethritis 70 per cent showed typical organisms and 29.9 per cent showed atypical organisms. It is

interesting to note that of the 29.9 per cent of cases that showed atypical organisms 16 $\frac{3}{4}$ per cent of these atypical cases developed complications identical with those of true gonorrhea. In my series of cases I found typical organisms in 65 per cent. The atypical cases were thrown out.

Gonorrheal urethritis may remain localized for years unnoticed, but the sequels and complications combined make it more to be feared than syphilis. The anatomical changes in the urethra are those of a high grade inflammation. During the height of the infectious process the meatus is red and swollen and covered with a thin mucopurulent secretion. In this secretion the gonococci may be found in varying numbers.

Often the dilated orifices of the glands in the anterior part of the urethra can be seen exuding minute drops of pus. This condition is shown by the endoscope to extend a short distance back, to be less intense near the middle, and often to assume a marked intensity near the internal orifice (H. Kelly). About the tenth day the inflammation begins to subside. The mucosa looks less red and edematous, the pus is diminished and the number of gonococci decreased.

Unless proper treatment is instituted the disease goes on to the chronic stage. This stage is characterized by small elevated, congested, cone-shaped areas, which are sensitive and bleed easily. Here and there these cone-shaped areas have undergone a necrosis and small ulcers have formed. The ulcers secrete a thin mucopurulent material which is composed of pus-cells, epithelial-cells and a few gonococci. These ulcers show little or no tendency to heal spontaneously, and, furthermore, stubbornly resist all forms of treatment.

The Glands of Skene are frequently involved and here the disease is particularly apt to linger in a chronic form. The pus can be milked out by pressure from above downwards, first on one side and then on the other. One or two drops of thick pus will often exude from the orifice from the duct just inside the urethra, giving evidence of its source by adhering more to the side from which it was squeezed.

Long after a gonorrhea is apparently well a fresh attack may start up by auto-infection from a chronic gonorrhea that has lingered in these glands.

Under the name of "Urethritis Externa" Guerin has described a

localization of the gonorrheal process of which E. Finger (*Die Blennorrhoe der sexual Organe und ihre Complicationen*, Leipzig and Wien, 1893, p. 300) speaks as follows: "The gonorrheal inflammation of the follicles at the orifice is either chronic when there are no symptoms and a small amount of pus, or acute and relapsing. One or the other follicle swells, giving the urethral orifice an asymmetrical appearance, and the mucous membrane over the follicle is reddened. Soon a little drop of pus escapes and the follicle closes. In a short time the same thing occurs again in the same follicle or another follicle, and so it continues for a long time.

"The only symptom of this unappreciated condition is some pain on touching the orifice. By a rupture of the abscess into the urethra and vagina simultaneously a fistula is formed.

As a rule the invasion of the urethra in the female is much the same as in the male. There is a slight tickling and burning sensation and some sero-mucous secretion in which little white particles may be seen suspended, that under the microscope are shown to be epithelial cells and gonococci. Then after a prodromal period of a few hours or a day, or two the acute stage develops with more or less severe burning in the urethra, rendered worse on urination, which soon becomes quite frequent.

Examination of the parts shows the urethral orifice to be very red and swollen, with perhaps a pouting prominence of its lips. A greenish-yellow discharge escapes in considerable quantity, and may cause redness and swelling of the parts around and beneath. By inserting the finger tip in the vagina, the urethra is found to be swollen and tender, and pressure from behind forwards causes pus to escape from the meatus. The local sufferings are quite acute and usually become worse when the bladder is involved. A slight rise of temperature may be noted. Patients will often hold their urine for hours to escape the burning and scalding.

In the majority of cases the acute stage begins to subside in about 6 to 10 days. The burning and scalding become less and less severe, and the tenesmus is less imperative, and the urination becomes less frequent and painful. The redness and swelling of the meatus subside slowly and the pus becomes whitish and mucoid. In this way matters grow progressively better until the chronic stage is reached. Then we commonly see a normal or only a slightly red meatus, from which by intravaginal

pressure on the urethra, a drop or two of vesico muco-pus or a thinner milky-looking fluid may escape. In this condition the patient may suffer no discomfort whatever, or she may have a slight smarting or sense of heat on urination.

Examination of the urine by the two glass test will show how far the morbid process has traveled. If the first specimen is cloudy and the second clear, it is certain that the bladder is not involved. If the second is cloudy or turbid, then it is certain the bladder has been infected. When the bladder has remained intact the first ounce of urine will contain clumps and filaments, which are made up of pus and epithelial cells and may contain a few gonococci. Examination of the pus in the florid stage shows pus-cells with many gonococci. As the secretion becomes more mucoid, epithelial cells show prominently in the field, with a diminished number of gonococci. In the chronic stage there are usually found some pus-cells, epithelial cells, and a few gonococci and the usual indifferent micro-organisms.

As a rule the diagnosis is easy. The history of burning and scalding urination, a red and swollen meatûs, covered with pus, and the finding of the gonococci put the question beyond a doubt. In subacute or chronic cases a little difficulty may be experienced, where the meatus looks normal or if there is little or no secretion or if the patient urinated a short time previous to the examination. In this condition tenderness of the urethra on intra-vaginal pressure is quite diagnostic of a urethritis. If any doubts exists the endoscope will reveal the small ulcers or congested areas, which are significant of a chronic urethritis.

In the treatment of this disease the prime essentials are cleanliness and intraurethral injections and constant care as to details. The patient should be made to understand clearly the gravity of the disease, and the sequels and complications that usually follow neglected cases, and she should be urged to continue under observation until pronounced cured. It is the duty of every physician to make thorough and painstaking examination to acquaint himself with the full extent of the disease. A physician who will conscientiously employ the proper local treatment, and not rely on the advertised quack internal remedies, will have successful results.

In the acute or painful stages of the disease no local treatment should

be given. The external genitals should be bathed frequently with mild antiseptic solutions, such as bichloride 1/6000 or a saturated solution of boric acid. The hot sitz bath may be used. Rest in bed is very desirable. The diet should be light and non-stimulating with large quantities of such diluent drinks as flaxseed tea. The bowels should be kept loose with saline purgatives. For the burning and scalding urination potassium acetate in from 10 to 15 grain doses three times daily usually gives the greatest amount of relief. If tenesmus is present tincture of hyoscyamus in from 10 to 15 drop doses should be combined with the potassium salt. The balsams and oils usually employed in the male are of no account and have a strong tendency to derange the digestive function. As soon as the inflammation in the urethra has somewhat subsided from the use of the foregoing measures suitable only for the acute stage, intraurethral injections of protargol 1 per cent are to be given daily. As the inflammation further declines the strength of the solution is to be increased gradually up to 2 or 3 per cent. Generally under this treatment the gonococci rapidly disappear and the discharge becomes less. After the gonococci have disappeared the protargol solution should be discontinued. The process of healing should be further aided by injecting a mild astringent solution of zinc sulphate every third day until the mucoid discharge ceases.

Vaginal douches are contraindicated, as they defeat the purpose for which they are intended by removing the protective secretion of the vagina. At the same time the nozzle of the syringe, which may have been lubricated with infectious pus, carries and deposits the gonococci high up in the genital tract.

The chronic stage requires a different treatment. Injections will not improve the condition. The only proper and satisfactory method is to expose the ulcerated or congested parts by means of an endoscope and directly apply to these infected parts a solution of nitrate of silver 20 gr. to the ounce every three to five days until the ulcers have healed. Skene's glands when involved should be emptied daily by pressure from above downwards on each side of the urethra. If there is a chronic diffuse inflammation about these tubules they should be laid open in the direction of the vagina and their lining mucous membrane burned with either a silver stick, carbolic acid followed by alcohol, or the actual cautery.

CONCLUSIONS.

1. All cases with a history of burning and scalding urination should be thoroughly examined for an existing urethritis.
2. If a urethritis is found, presume it is of a gonorrheal origin, if no foreign is present.
3. Institute a thorough treatment in all cases, for, if a cure can not be effected complications may be prevented.
4. Employ the vaginal douche only after all traces of the primary infection have disappeared and never in the early stages.

SOME OBSERVATIONS ON THE SIGNIFICANCE OF THE SO-CALLED "OCCULT HEMORRHAGES" IN THE DIAGNOSIS OF ULCER AND CARCINOMA OF THE STOMACH.*

BY DR. JULIUS FRIEDENWALD AND DR. L. J. ROSENTHAL.

It is our desire to call attention to the significance of two very simple tests, the importance of which was first pointed out a few years ago by Boas as a means of detecting minute quantities of blood in the gastric contents and feces. This investigator showed that by aid of the well-known Weber test, as well as by Klunge's aloin test, it is a simple matter to detect a minute quantity of blood having its origin in the stomach too insignificant to be seen by the naked eye and yet which, by its continued persistence, may prove a serious menace to life.

In his first communication Boas pointed out the fact that that form of bleeding which was too insignificant to be detected by the naked eye, and which he termed "occult hemorrhage," occurred only in certain gastric conditions. He never found it in the gastric contents in chronic gastritis, hyperacidity, or hypersecretion; it occurred occasionally in gastric ulcer with or without consecutive stenosis; it always occurred in cancer of the stomach, as was shown by an examination in 20 cases.

In a further communication Boas showed that errors due to slight bleedings induced by introducing the stomach tube, causing minute erosions, could be avoided by investigating the feces rather than the gastric contents. However, in the examination of the stools for these hemorrhages certain precautions must be taken, namely, to exclude food containing fresh unboiled or medium-done meats and sausage from the diet for two days before the test is undertaken, as well as to ensure soft movements by means of Carlsbad salts. Occult blood was not found by us in 92 examinations in 47 cases of chronic gastritis, in 42 examinations in 15 cases of atony of the stomach, in 108 examinations in 42 cases of

* Proceedings of The Medical and Chirurgical Faculty of Maryland.

hyperchlorhydria, in 21 examinations in 8 cases of hypersecretion, in 16 examinations in 9 cases of acute gastritis, in 57 examinations in 25 cases of nervous dyspepsia. So significant is the fact that we have frequently been enabled to rely on the constant absence of this sign as evidence sufficient to exclude the presence of ulcer and cancer, and, on the other hand, as evidence in favor of the presence of either a gastritis or some form of gastric neurosis.

Thirty-five cases of ulcer of the stomach were examined as to the presence of occult blood in the stools. This condition was found in 26—74 per cent. It was not noted, however, at every examination; most frequently, however, before the patient had been placed under treatment and when the pain and nausea were extreme. After the patient had been placed upon the ulcer cure (rest in bed and a diet mainly of milk) for a period of days the occult bleeding usually disappeared. The continuance of occult bleeding after a faithful trial of the ulcer cure has been undertaken is indicative of the fact that a healing of the ulcer is impossible, and surgical interference must then be considered. We have found occult bleeding a most valuable aid in diagnosis of this disease, especially in the cases in which the symptoms are not decisive and in which the diagnosis varied between gastralgia and ulcer. In every instance in which the ulcer treatment was undertaken improvement in the patient's condition indicated the correctness of the diagnosis and the value of this sign. Occult bleeding has often as much significance as pronounced hemorrhage and will frequently indicate the presence of an ulcer long before visible hemorrhage is present.

The presence of occult blood can be utilized, too, in testing the effect of various forms of treatment in ulcer of the stomach. During the ulcer-rest cure the occult bleeding rapidly disappears. On the other hand, Schloss has shown that bismuth, which was formerly considered to have a specific effect in the treatment of this disease, can no longer be considered in this light.

Twenty-three cases of cancer of the stomach were examined by us for occult bleeding. In but very few examinations was the absence of this sign noted. It was found constantly in 19 of the 23 cases—82.6 per cent. In the other four this symptom was occasionally noted. So constant is this finding that it serves to differentiate cancerous processes of the stomach from other conditions.

Occult bleeding is found early in the disease often long before the physical signs of a tumor become manifest. While the presence of this sign alone, however, has no significance, in addition to other clinical evidence, we have found it of such practical value that we should urge a careful investigation for occult bleeding in all obscure forms of gastric disease.

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THE JOURNAL
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COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

ANNOUNCEMENT.

The commencement exercises this year will be held on the evening of June 3.

The annual alumni banquet will take place the same evening. All the arrangements for the dinner have not yet been made, but since Dr. Brack is the chairman of the committee, we can state with assurance that all plans will be made in ample time and thoroughly executed.

On account of the fact that the commencement this year immediately precedes the meeting of the American Medical Association at Atlantic City it is expected that a larger number than usual of alumni from a distance will be present. There will be no reserved seats at the commencement. Walk in and take the best in the house.

All who expect to attend the banquet should notify Dr. Chas. Emil Brack, 500 E. 20th St., so that ample notice can be given to the caterer.

SET THEM UP.

There are a considerable number of pelvic and abdominal conditions, and especially the infections, that are influenced directly by the posture of the patient.

Practically all puerperal patients do much better if they are not confined too closely to the recumbent position. From the first day the

patient should be allowed to sit up to urinate and defecate. By this means the use of the catheter is often avoided, diminishing the risk of cystitis, and the chances of infection are decreased by promoting vaginal drainage. The patient should early be propped up on pillows or a back rest for short periods, and her position changed from time to time. Don't keep puerperal patients flat on their backs for ten days.

For over twenty years we have been putting that class of puerperal infections where there is no peritonitis in the erect position with most excellent results. Many of the so-called cases of sapremia require nothing else in the way of treatment. These patients may be propped up in bed with a high back-rest, but the most satisfactory way is to put the patient in an arm-chair. The Morris chair or the old-fashioned rocker are the best types, because in these the patient can have her position altered from time to time very easily. High temperature is the most positive indication for the erect position. Set them up!

More recently the same principle has been applied to a much wider field of usefulness. All cases operated upon for pus in the pelvis, whether the drainage is by the culdesac or through the abdominal wall, are immediately put into the erect position. The same applies to all cases of peritonitis whether of tubal or appendicial origin. Drain them; set them up.

It is undoubtedly true that the pelvic peritoneum is better able to take care of infections than is the abdominal peritoneum; consequently it is found that peritoneal infection without drainage does better in the erect position than in the recumbent. The infection becomes more readily localized and the danger of a general peritonitis decreased.

Set them up!

DRAINAGE OF THE BILE TRACT.

Infection of the gall bladder and hepatic ducts is a condition that deserves more consideration than it has received. It is of frequent occurrence; it gives rise to distressing symptoms and to grave results.

The only measure giving the patient prompt relief is drainage. There are three portions of the bile tract that may be drained directly: the gall bladder, the common duct, the hepatic duct.

The line of incision employed to reach the point to be drained is made in various ways, but the straight incision through right rectus muscle is one of the simplest and most satisfactory. By it very little damage is done to the abdominal wall and a good exposure of the field of operation is obtained.

The gall bladder may be drained by the direct insertion into it of a rubber tube. The opening in the bladder is drawn snugly around the tube by a purse-string suture. The bladder may be left free, but most operators prefer to anchor it to the peritoneum or fascia by one or more catgut stitches. The outer end of the tube can be inserted into a bottle under the outer bandage. The bottle can be emptied as often as is necessary without disturbing the wound. The collection of the drainage in this way, instead of allowing it to soak into the dressings, is a great comfort to the patient as well as to the attendant.

The common duct may be drained directly by incision and the introduction of a tube of proper caliber. This is not practical unless the duct has been dilated. Another method is to stitch with a fine catgut a notched tube over the point of incision. In both instances secondary drains should be put in to assist in the discharge of any leakage.

The drainage of the hepatic duct other than indirectly by the methods mentioned is a more difficult matter; but in cases where the liver is mildly infected it is of great importance.

In a recent number of the *Journal of the American Medical Association* Dr. Charles Greene Cumston discusses the drainage of the hepatic duct. He states that drainage can be accomplished indirectly by the insertion of a tube through the gall bladder and cystic duct to the hepatic; by the insertion of a tube through an incision in the common duct until it passes into the hepatic. Directly, by incision of the hepatic duct and the introduction of a tube; by incision of the hepatic duct through an opening in the substance of the liver. The demand for direct drainage of the hepatic duct is present only in cases where there is dilatation following obstruction associated with infection. To secure satisfactory results the obstruction must be removed and the drainage continued until the bile becomes normal.

Obituary.

Parke, Davis & Company passed the following resolutions on the part of the stockholders, employees, and others interested in the house on the death of Mr. Buhl, the ex-President:

"Ten and a half years ago Theodore D. Buhl cast in his lot with this house. Throughout that period he has given us the benefit of his large experience, his sound judgment, his great power in the commercial world, his granite credit reared on an unwavering honesty. As President of the house he was the perfect type of integrity and fidelity to all the stockholders. His high sense of duty as a trustee pledged to administer the property and guard the interests of others was ever uppermost in his thoughts. The peculiar responsibilities and hazards of our work—our obligations as purveyors to the medical profession and to suffering humanity—were to him always a solemn appeal. The ultimate triumph of character in business was with him a conviction as deep and strong as instinct. The remote future and the distant prize concerned him more than the present gain.

"The strength which he gave this house and all the many enterprises in which he shared signally exhibits what the world should realize especially at this hour—that rich men of unflinching honesty and sound judgment are of inestimable value to their communities. They are the employers of labor, the authors of new industries, the creators of new values, the pioneers who open up vast avenues of opportunity for their followers. As they succeed or fail, the comfort, the very bread of thousands is assured or endangered. We hear much these days of unscrupulous predaceous wealth, but what of the type of Theodore Buhl—what of the men who consider the trust of their fellowmen the best of their possessions, who have a horror of stock-jobbing methods, who never seek an unfair advantage, who never lend their names to a dubious enterprise?

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"On behalf of the stockholders, employees, and executives of Parke, Davis & Company we record this testimony to the lasting service rendered us by our lamented President. To the members of the bereaved family we offer our warm and heartfelt sympathy. May strength be theirs to bear their sorrow. May they find much comfort in the memory of a life rich in well-doing and in good repute."

Personal Notes.

DR. JOHN C. MORFIT has been elected president of the St. Louis Medical Society.

DR. HARRY HUBBARD was married to Miss Carrie Bullard, December 5, 1906.

HON. CHAS. JACOBUS HALPER and MRS. BARBARA J. COLLINS were married in New York, January 26, 1907.

Correspondence.

GRAFTON, W. VA., April 8, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—On Easter Sunday morning, March 31, 1907, Dr. Charles F. Reilly, of the Class of 1902, died after an illness of three weeks, at his home in Blackstone, Mass.

"Charlie" Reilly, as we all loved to call him, never robust, but always cheerful, loved by all who knew him, upright and honest, a credit to his alma mater and to himself.

Being a member of his class and a close companion of his, I know whereof I speak when I say, no brighter man or better student ever graduated from the P. and S. He was greatly loved by those who knew him intimately for his manly qualities and true friendship.

He was a man of brilliant attainments and a bright future seemed assured him. Not only is he a great loss to his parents and bereaved wife, but also to his classmates and all who knew him.

Death, at any time, is always sad, but coming as it did to Dr. Reilly, in the prime of life, at the beginning of a bright career, it is sad, indeed.

JOHN H. DOYLE, '02.

CHICAGO, ILL., March 29, 1907.

TO THE EDITOR OF THE JOURNAL OF THE ALUMNI ASSOCIATION,
Baltimore, Md.

Dear Sir.—Enclosed please find check for five dollars as part of my subscription and stop sending me our journal for this summer, as I am going for a few months to the old country. There will be a medical congress of Slavonic physicians in Leutberg, Austria Galicia.

I may inform you that I discovered a new compound of silver which I call "Sribol." It is colloidal silver prepared from formalin. Therefore when once introduced in glycerine solution on an iodoform gauze tampon into the uterus will keep it sterile for 24 hours.

I am going to that congress to present my discovery and will return in four months.

I am now Professor of Obstetrics in the National Medical University, at Chicago, Ill.

Yours respectfully,

W. J. SIEMINOWICZ, '93.

ATLANTIC CITY, N. J., April 4, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find two dollars for my subscription to the ALUMNI ASSOCIATION JOURNAL. If my bill is more kindly let me know.

I am living in the "City by the Sea," and would be glad to see any of the boys of the college any time they are in the city.

Dr. Sherman Demill, Class of '87, has been dead some ten years, having died of tuberculosis.

Yours very truly,

C. GARRABRANT, '86.

ATLANTA, GA., April 1, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—I enclose check for two dollars for THE JOURNAL OF THE ALUMNI ASSOCIATION of the College of Physicians and Surgeons. I enjoy reading the journal and hope the Alumni will support it.

Yours truly,

W. L. CHAMPION, '91.

READY BRANCH, N. C., March 28, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Sometime ago you sent me a bill of my dues, which were two dollars. You will find enclosed two dollars which place to my credit. Wishing the JOURNAL and you all much success.

I am yours truly,

ALBERT J. ELLER, '93.

UPPER MARLBORO, MD., March 29, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

My Dear Doctor.—Your letter is at hand and I take pleasure in sending you the list of graduates of '79. I hope to be with you in May at the annual banquet but expect to see you in April at the meeting of the Faculty. I regret very much to learn that the class lists of the college have not been kept and reckon you will find it a very difficult task to get them accurate now. With kind regards and best wishes,

I am sincerely yours,

L. A. GRIFFITH.

FLANDERS, N. J., March 26, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—The last issue of the ALUMNI JOURNAL just came, and that again reminds me I should do my part to keep the JOURNAL in a healthy condition. Enclosed find check for four dollars, for which please give me credit.

I came to this village in October, 1904, married one year later. I am the only physician within a radius of eight miles. I follow the regular routine of a country doctor.

I always enjoy reading the communications and personals. I would like to hear more from members of my class.

Wishing the JOURNAL success,

I am very truly yours,

LANCELOT ELY, '04.

SMOKE RUN, PA., March 11, 1907.

Dear Brack.—Will you please advise me date of P. and S. commencement next month. I am going down if possible, and would like to see some of the '95 boys turn up once, as I have learned practically nothing from many of them since graduating. I am getting along well, and have no complaints to offer.

Wishing you well, and believe me,

Yours sincerely,

H. S. WILSON.

COTALATO, MINDANAO, January 27, 1907.

Dear Doctor.—My only excuse for remaining silent so long is procrastination. Since leaving Baltimore I have visited many places. In the spring of '05 I went to Alaska with the coast survey and remained there until September, when I was ordered out here. I came out on the good ship "Korea" to Japan and China. I had two weeks in Japan and visited all the large seaport towns and made several side trips by rail. In China I got to Shanghai and Hong Kong. After going through the walled city in Shanghai I realized that Baltimore can boast of wide streets and good drainage. Since being in the islands I have been to all the important islands and cities, and have been at this post for three months and hope to remain until I return to the States, which I believe will be in September.

I met Dr. Vogel in Manila, Dr. Pond in Cebu, and while in Manila, a few months ago, met Dr. Owens at the Division Hospital.

While I was with the survey I did not have much to do, but since being with the army I have not had so much idle time. In a few days I hope to be able to take some pictures of the lepers in the colony just across the river from this place. If they turn out all right I will forward you a copy.

With regards to yourself and all,

Fraternally yours,

CHARLES H. HOLLIDAY.

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Vol. X

No. 2

JULY, 1907

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"FAMOUS PHYSICIANS."

ORIBASIS, ACTIVE ALEXANDER OF TRALLAS, PAVLOS AEGIDIUS.
360-600 A. D.

By DR. H. M. COHEN, '96.

In taking up the history of medicine, we find ourselves continually overlapping into the domains of theology. From the days of Adam and Eve, mankind, through all the ages, has, to a great degree, looked upon the healing art as, in some manner, connected with the supernatural. Disease was either the result of divine wrath, or could be expelled by an appeal to divine power. Every age and race prayed and begged for relief. The Hametic, the Semitic and the Aryan, however much they differed in other particulars, were on common ground in questions of health and disease. They all prayed, offered up sacrifices, appeased the god or gods, had faith and believed. This has been the history of the mass of mankind. So it happened that, from the earliest days, medicine and religion were put in the same bed.

In Assyria, Phœnicia, and Egypt, as well as among the Biblical Jews, Greeks, and Romans, we find medicine inseparable from the priest-craft.

Touching on the unknown, the ecclesiastical bodies recognized its value as an aid in their work, and, from the time of the mythological Olympian deities down to the missionary doctors in heathen lands in

our own day, every phase of religion has made use of the healing art in the propagation of its tenets.

But experience has fully proven that science does not thrive on theology. Analyzed to its ultimate principle, medicine is more or less of an exact science, in so far as there is a cause for every effect, and an effect from every cause. With Hippocrates it started out on a more or less direct course, and to reach its destination, which is perfection, it could not be led aside by theology. The principles of the cure of disease are steadfast and unchangeable, and follow out certain inviolable, though perhaps non-understandable, laws of the body, and have been so since the breath of life was blown into the first man. Religion, however, has been, from time immemorial, as varied as the colors of the spectrum, and all attempts made to mould the healing art to its variable forms must result unfavorably to the art.

Without entering into any theological speculation, we need only state that, at least in so far as the scientific treatment and cause of disease is concerned, there could never have existed such a factor as the supernatural. The attempt of the early church to prove the contrary resulted, for the time being, in the almost complete destruction of medical science; and, had it not been for the fortunate translation into Arabic of the works of Hippocrates and Galen, all the accumulated knowledge of the ancient period would have been lost.

But religion has always been an index of the intelligence of the age, and, in so far as medicine is concerned, we find that, in common with the decline of all the arts and science, it descended into abysmal darkness.

For many centuries after Galen we note no advance. This interval was the age most given over to a belief in miracles, and, with this as a competitor, little progress could be made. It was much easier and pleasanter for an invalid to worship at some altar, or wear an amulet, in the hope of recovery, than to be physicked; and it heightened the ecclesiastical influence by encouraging the miraculous healing power of faith. Under such influence, the medical science became abysmal.

In this period we find the world's saddest story. We turn over the

pages of these dark centuries with disgust and horror at the chain of frailties and blood-lust in perpetual succession. It is a story of the mouse being swallowed by the cat, and she, in turn, being masticated by a larger animal. We see strife, fanaticism and villainy constantly paraded under the holy colors until in vain do we look for such an institution as the brotherhood of man. We discover every great truth burdened and disguised in ignorance; and, like the oasis on the desert, it is only occasionally that we make out true purity. It seems that all humanity has sunk to the level of the wild beast of the jungle, in its desire to gorge on the carcass of the weaker; and we find nations engaged in gigantic struggles, for no other purpose than their spoliation and utter annihilation. Is it any wonder that medicine and its practitioners should be engulfed in this disgraceful cataclysm, and sink to the level of their surroundings?

Civilization was at a low ebb, and so was science. The healing art proved no exception, and it is with little success that we search for characters worthy of record.

As has already been stated, medicine entered upon its blackest period. From the days of the apostles, the healing art could make no headway against the belief in miracles. As the faith in the new religion spread its wings over the masses, so the very reason for the existence of medicine seemed abolished. Cures were to be effected by prayer and belief, and the function of the doctor was absorbed by the teacher of religion. The church became the donor, and exercised its authority to increase its ownership.

Finally, there sprung up the monk-hood or monasteries, the members of which, along with their other self-inscribed duties, undertook to heal the sick.

The first monks, of which we have any knowledge, however, antedated those of the followers of the new religion. They were known as the "Essenes," and are described by Josephus as belonging to one of the three Jewish sects that flourished in the second century before Christ. One of their tenets was to succor the sick. "They also take great pains in studying the writings of the ancients and choose out of them what is most for the advantage of their body and soul; and they in-

quire after such roots and medicinal stones as may cure their distempers" (Josephus). Their example was, in a measure, followed, in later years, by the Benedictines, and other orders who included medicine in their curriculum of study.

Out of the teachings of the Essenes ultimately grew a revival of the cabalistic treatment of disease. The sick were to be cured by means of certain mystical signs, brought into play by corresponding forces in the other worlds, a knowledge of which could be obtained only as the result of seclusion, piety and meditation.

The idea appealed to the decaying Greeks and Romans, and was finally taken up by the early Christians.

It would transcribe the limits of this work to give even an outline of the part superstition has played in the history of medicine. Suffice it to say that, even in our own enlightened day, we are not entirely free of its baneful influence, and no doubt the reader comes into frequent contact with it. It would be perhaps quite a shock to some of us to learn how many amulets and charms are now, by more or less intelligent people, being worn "to keep off evil," and cure disease. Among the less advanced nations it is quite a common custom. From the Philippines instances are reported where the blind, unquestioning faith placed in the "Antinganting" worn around the neck, is so great that the wearer exposes himself to the fire of a Krag with an absolute certainty that the charm will render the bullet harmless. But, we need not go far from home to see examples of superstitious credulity; and perhaps we should not expect to find a higher degree of civilization in the inhabitants of the "twilight ages."

So we learn that, from the day of Galen, the healing art made a gradual descent, along with the other branches of science, and, not until the Byzantine period, did it recover anything like its former prestige.

For a few centuries the methodic school continued at Rome; and among the few physicians of importance may be mentioned Coelius Aurelianus, who, next to Celsus, was the most influential of the Latin medical writers. Two others of note in this period were Aretaeus of Cappadocia, and Alexandre of Aphrodisias, the latter being the author of a treatise on fevers, still extant. Oribasius, Alexandre of Tralles,

Aetius, and Paulus Aegineta lived in the third, sixth and seventh centuries, A. D., and are among the limited number of physicians of note during and following the Roman decline. These were largely compilers, and contributed little of extraordinary value.

Oribasius, born about 360 A. D., was a prolific writer, and indited seventy books, of which about seventeen have survived the ages. He followed most minutely the anatomy of Galen. He describes a peculiar form of madness, which he calls "Lycanthropia." "Those suffering from this dread disease are accustomed to wander out during the night, visit sepulchers, and howl like wolves. They are pale; their vision is feeble; their eyes and tongues are dry, and their flow of saliva is stopped. They are thirsty, and their legs are incurably ulcerated, as a result of frequent falls." Russell traces this same disease through St. Luke, and Forrester, in the sixteenth century.

Oribasius exercised a great influence over the Emperor Julian, with whom he had been very friendly before his ascent to the throne.

He was sent by Julian to Daphne, located near Antioch, where he was to inquire of the oracle the probable result of an expedition the Apostate intended to send to restore the altars of the old gods. But Oribasius returned, with the information that, when he had put the question to the oracle in the name of the Emperor, the reply he received was that "they were now all silent." Julian was a confirmed believer in dreams, and his friend-physician was often called upon to translate them.

Oribasius fell with Julian, and was exiled among the barbarians, among whom he exercised his great skill, and became exceedingly popular. He was later recalled by Valentinian III, and, notwithstanding his connection with Paganism, received many honors, before he finally died at Constantinople, about 390, A. D. Emperor Theodosius, as a result of the influence of St. Ambrose, was converted to Christianity, and, by official decree, declared the destruction of Paganism. Under his orders, Bishop Theophilus, of Alexandria, took possession of the temple of Serapis, and, with unexplainable bigotry, destroyed the great and valuable collection of works composing the library. From this date begins the decline of the great school of Alexandria.

Aetius was a native of Amida, Mesopotamia, and lived about 500 A. D. He studied at Alexandria, and, in addition to being a court physician at Constantinople, was also a captain of the guard. His greatest work consisted in the compilation of all the extant medical data of antiquity, and comprised sixteen books. His principal contribution to anatomy was the separation and description of the parotid and sub-maxillary glands. In his surgical teachings he displayed a wide range of accomplishments, and, according to Moir, he practiced scarification of the legs in anasarca; used the actual and potential cauteries; enucleated hemorrhoidal tumors; operated for aneurism, and resorted to internal remedies, with an idea to the dissolving of urinary calculi.

He distinguished the symptoms of various intermittent fevers, and discussed the eye, gout and urinary calculi. An important contribution was a report on Egyptian Pharmacy.

Following closely on Aetius, is Alexander of Tralles, who was born in Lydia. His time is given doubtfully as being in the sixth century, in the reign of Justinian. He was one of the four distinguished sons of a physician, from whom he received his first medical instruction.

He later studied in Italy, France, and Spain, and, finally, settled in Rome, where his superior skill and intelligence acquired for him an extensive reputation.

By many writers he is placed in the same class with Hippocrates and Galen; and all unite in designating him as a fine example of the ideal physician.

As with Aetius and other predecessors, he follows closely the anatomy and physiology of Galen, but amplifies and beautifies many of his crudities. He believed in the Hippocratic theory of the humors, and gave a good description of pleurisy, and inflammation of the liver. He also describes the seat, varieties and management of dysentery, and makes a study of melancholia. A work of importance is his treatise on intestinal worms, which he divides into the ascorides, lumbrici and Tæniæ, and for each of which he gives symptoms and treatment.

As regards blood-letting, he contends that, as the blood is a continuous system, it makes no difference in what part the operation is performed for the relief of symptoms. He laid down the rule that, in the

treatment of disease, attention should be largely paid to the circumstances and environments of each individual case, and that age, sex, climate, and constitution are great factors in the tendency towards health, which nature encourages.

Paulus Aegineta was noted, principally, for his obstetrical and surgical work. He lived in the seventh century, and was the last great medical character before the approach of Mohammed.

His contributions to surgery were the result of much personal experience. He differed from the teaching of Aetius, and agreed with Hippocrates as regards blood-letting, maintaining that the operation should be performed near the point affected. In treating violent ophthalmia, he introduced arteriotomy, and recommended "freely opening a vein, to encourage the passage of a calculus, in its way through the ureter." (Moir.)

He advocated the use of caustics for the purpose of opening "internal abscesses," and described the advantages of doing paracentesis, in the treatment of ascites. His operation for stone in the bladder is described by Moir as follows: First, he endeavored to ascertain the situation of the calculus by the rectum; then made his incision, not along the raphe of the perineum as recommended by Celsus, but to one side of it.

He divided aneurisms into two classes: First, those that result from anastomosis; and, second, those that follow rupture. He excised the mamma by a crucial incision. The same learned author already quoted, declares that Paulus was the first surgeon to perform trachelotomy. His method was to make a transverse incision between the third and fourth rings of the cricoid cartilage, avoiding the great vessels.

His reputation as an obstetrician was no less than that of surgeon. Head and foot presentation, he declared, to be nearly equally natural, and all others were to be transposed by art to one or the other, if possible. He was the first to suggest embryotomy, where the head was too large to traverse the natural passage, having previously ascertained the death of the child. He advised against undue force being used in the extraction of the placenta, to prevent partial inversion of the uterus.

A STUDY OF THE GROUP ACTINOMYCES.*

WITH THE REPORT OF A PATHOGENIC SPECIES FOR MAN.

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HISTORICAL REVIEW.—Before describing the organism which was isolated from an abscess of the lung, I shall review some of the important points concerning the group actinomyces and its increasing importance in pathology.

In 1875 F. Cohn¹ described an organism which Foerster had found in the human lacrymal canal. This he described as a filamentous growth which showed true branching forms. Despite this description the organism and others resembling it were confused with cladothrix by a number of different authors. Even such men as Baumgarten² and Nocard³ placed actinomyces and streptothrix du farcin du bœuf in the genus cladothrix. The demonstration of actinomyces by Nocard as the cause of a disease in animals soon caused investigators to study it more closely, and it was soon separated from cladothrix, since the false branching of this organism sufficed to distinguish it from a streptothrix with true dichotomous branching.

The streptothrix † since this time has been found in a large number of pathological and saprophytic conditions.

Almquist⁴ isolated one species from a case of meningitis, and found another variety in water, which gave a white growth. Gasperini⁵ obtained streptothrix Foersteri from the air, and found a second species which was negative when inoculated into guinea-pigs and rabbits. This was chromogenic, forming a brown color.

The observations of Eppinger⁶ are of special interest.

He observed a streptothrix in a case of meningitis and cervical abscess, which caused pseudotubercles when injected into the tissues of guinea-pigs and rabbits. The branching threads stained by Gram's method, and formed coccus-like spores. Gruber⁷ also found one of these

* Extracted from the American Journal of the Medical Sciences, November, 1904.

† The name streptothrix is used in an historical sense, but the name actinomyces is later given to the entire group.

organisms which produced abscesses in guinea-pigs, and Doria⁸ by exposing gelatin plates to the air cultivated thirty-five colonies of streptothrix alba of Gasperini, and seven colonies of streptothrix nigra. The four other chromogenic species were whitish-yellow, pink, orange, and violet. These species all seemed similar under the microscope, and formed spores. Sauvageau⁹ also found two specimens of a streptothrix in gelatin plates exposed to the air.

Bollinger and Harz¹⁰ first called the fungi found in actinomycosis by the name of actinomyces. Following this observation a large number of articles appeared on this subject. Boström¹¹ has studied and carefully described one form of streptothrix actinomycotica which is aerobic, and pathogenic for man and cattle, and not pathogenic for laboratory animals, such as guinea-pigs and rabbits. Wolf and Israel¹² soon described another species which differed from the former in growing best under anaërobic conditions, and in being pathogenic for small laboratory animals. They obtained it from two cases in human beings. Levy¹³ found an anaërobic species in five cases of human actinomycosis, and Asthoff²¹ isolated this species from a case of primary actinomycosis of the lung.

Streptothrix has been observed quite recently in a number of diseased conditions in animals and human beings.

Silberschmidt¹⁴ found an organism in the lungs of a goat with a disease resembling tuberculosis. He called it streptothrix capræ. This species consisted of filaments staining by Gram's method, which grew on all the culture materials and produced abscesses or pseudotubercles in guinea-pigs and rabbits.

Aoyama and Miyamoto¹⁵ described a form of streptothrix which they cultivated from the pus from a lung affected with caseous pneumonia and purulent pleuritis. The organism was present during life in the sputum. It proved as resistant to acids as the tubercle bacillus, but grew readily as a streptothrix on the various media, and produced pseudotubercles and fibrinohemorrhagic exudations in animals.

Two cases of necrotic bronchopneumonia have been recently reported by Norris and Larkin¹⁶ as caused by a streptothrix. Both patients suffered from clinical conditions resembling lobar pneumonia, and at the autopsies the lungs showed complete consolidation, and one

case also exhibited a fibrinous pleuritis. The lungs in both cases, upon histological examination, showed a necrotic or purulent bronchitis and purulent exudation in the alveoli with small diffuse abscesses. A few threads of the streptothrix were found in the air cells, but the necrotic bronchi contained many colonies of the streptothrix. The lung also contained many streptococci. These organisms were stained by Weigert's method.

Some difficulty was experienced in separating the streptococci from the streptothrix but by cultivating the material from infected rabbits on sterile normal kidneys, and then transferring the colonies to broth, a pure culture was at last obtained.

This then grew on the usual culture materials, although it had first refused to do so. The injection of the streptococcus and the streptothrix together into rabbits produced suppurative and necrotic pneumonia and bronchitis, but when pure cultures of the streptothrix were injected into the tissues death did not often occur. These injections, however, caused abscesses, and pseudotubercles, and the organism can be considered as pathogenic.

Fullerton¹⁷ found a pathogenic streptothrix in the case of a woman, aged forty-six years who had suffered from a cough for twelve years. On admission to the hospital the patient had bloody expectoration and pulmonary rales, and an abscess in the left axilla and over the clavicle. The streptothrix was found in the sputum, and a pure culture showing mycelium and spores was obtained from the pus. It grew on glycerin-agar and broth, and was not pathogenic for rabbits. Scheele and Petruschky¹⁸ also report a case of pulmonary infection due to this organism. The woman suffered from fever, thoracic pain, and pulmonary symptoms. Small tumors filled with pus appeared at different points under the skin. The streptothrix was found in the sputum and pus during life, and an ante-mortem diagnosis of streptothrix infection was made. At the autopsy the streptothrix was found in the solidified lung, and the metastatic abscesses. It grew on gelatin, and in bouillon.

In the chronic inflammatory process usually affecting the tissues of the foot called mycetoma, or Madura foot, a form of streptothrix has been isolated from one variety of cases. In the pus from the oehrid,

or pale variety of the disease, granules have been obtained which grow on potato as a typical streptothrix. Vincent²³ and Boyce and Adams²⁹ have all probably cultivated a form of streptothrix from such cases, which belongs to a different species of the genus streptothrix from that of *actinomyces bovis*.

Sabrazés and Riviére²² isolated a form of *actinomyces* from a case of abscess of the brain, lungs, and kidney. This organism stained by Gram's method, showed irregularity in staining, and true dichotomous branching. Its mixture with other bacteria prevented its further study. Berestneff, in a Russian publication quoted by Hektoen, also reported a specimen of *actinomyces asteroides* which he isolated from an abscess of the brain.

It will be noted that thus far I have used the names which have been applied in a rather confusing way to the various species of this group. Hektoen²⁴ and later MacCallum²⁰ have pointed out that priority is alone valid in determining nomenclature, and after weeding out the various other names for this genus they correctly conclude that *actinomyces* must be used for all the species of this group. These organisms in the future will, therefore, be called *actinomyces*.

MacCallum also isolated a specimen of *actinomyces asteroides* from a case of general subacute purulent peritonitis in a child aged three years. This condition followed a gastrostomy for the relief of an oesophageal stricture. As this organism will be minutely described in the section on classification, no further comment will be made at this time.

DESCRIPTION OF CASE AND ORGANISM.—The organism which I shall describe was obtained in pure culture from an abscess of the left lung in a case of marasmus in the service of Dr. John Ruhräh at the Garrett Hospital.

CLINICAL HISTORY.—The child was a white male, aged twenty-eight days. The temperature showed no elevation, and the child died at last from wasting and exhaustion. Cyanosis was present, the spleen was palpable, and a few rales were detected in the lungs.

RECORD OF AUTOPSY.—The body weighed four pounds, and the cervical glands were enlarged. The subcutaneous and subperitoneal fat was light yellow and of a granular appearance. The thymus gland

only weighed 2.1 grams, and measured 3.5 by 2 cm., being 6 mm. in thickness. This organ, therefore, showed the atrophy characteristic of marasmus.

The lower portion of the lower lobe of the left lung at the middle part of its diaphragmatic surface showed a small projecting area, which, on section, proved to be a pus cavity about the size of a pea. All of the other viscera were normal in appearance.

A culture from the abscess on blood serum gave a pure growth of the actinomyces to be described farther on.

HISTOPATHOLOGY.—*Lung Abscess.*—The lung tissue surrounding the abscess is deeply congested, and the air cells are filled with an exudate consisting of red blood corpuscles and endothelial cells. The abscess itself simply consists of a collection of polymorphonuclear leukocytes, containing many branching threads staining by Weigert's method.

Lung.—Left lung. The smaller bronchi are filled with an exudate consisting of polymorphonuclear leukocytes, red blood corpuscles, and cells with round nuclei surrounded by eosin-staining protoplasm. The lung tissue surrounding these bronchi has undergone great thickening, and is richly infiltrated with young connective-tissue cells with round, oval, or elongated nuclei. Many of the interalveolar septa are greatly thickened, and some of the air cells and infundibula adjacent to the inflamed bronchi are filled with pus cells. There is also marked congestion of the interalveolar capillaries. On staining sections by Weigert's method a firm network of branching threads is to be seen in the abscess. No coccus-like bodies or clubbed ends are present and the growth consists entirely of threads.

Thymus Gland.—Fibrous capsule somewhat thickened. The interlobular tissue is markedly thickened, cutting up the lobules into irregular masses. Some of these irregular lobules contain as many as fifty degenerated Hassall's bodies. These bodies are dilated, and they usually contain a central body composed of concentrically arranged hyaline material. Between this and the lumen there is usually a peripheral rim of polymorphonuclear leukocytes, although sometimes this rim is simply a clear space. This rim is surrounded by a single layer of flat cells resembling endothelium. There also seems to be an increase of reticular tissue and reticular endothelium within the lobules, and

the lymphocytes are not as numerous as those in the normal gland. Sections were made from all of the other viscera, but no abnormal changes were found. Cultures from the viscera remained sterile. The macroscopic and microscopic changes, therefore, simply indicated a case of marasmus in which the terminal infection was caused by a species of actinomyces.

DESCRIPTION OF THE ORGANISM.—The serum tube, which was inoculated from the pus from the lung, did not show any growth for six days, and at the end of this time a number of fine, white, pinpoint dots appeared on the surface of the medium.

Morphology.—In fresh specimens the colonies consist of branching threads about twice the transverse diameter of a typhoid bacillus. In the meshes of these threads and at the distal ends there are a number of round bodies free in the fluid.

When the colonies are teased out or gently crushed they can be mounted on a slide and stained by Gram's method. The threads are long and often show side branches. The staining is interrupted or irregular, areas of dark-blue protoplasm alternating with unstained areas of protoplasm. The spores are often grouped around the distal end of a thread, and are about twice the size of an ordinary micrococcus. There are also smaller round spores free in the field, often arranged in chains resembling streptococci.

Spores.—When a colony is stained by the Ziehl-Gabbett method the numerous ovoid spores retain the red eye. Some of these spores almost resemble bacilli, although they are not as long and thin as the tubercle bacillus. Most of the hyphæ or threads of the colonies stain blue, showing no resistance to acids. A few, however, stain bright red, and these sometimes seem to cut off their ends by transverse fission and form spores. These are the special hyphæ mentioned by Poncet and Berard in their book on *Actinomycosis*, which form the spores, while the ordinary mycelium does not form any spores. On staining with carbolfuchsin the irregular, almost striped staining is well seen, but Loeffler's and Neisser's stains show no metachromatic bodies. This result differs from that obtained by MacCallum, who obtained many bluish-black metachromatic granules. He did not obtain any spores, but our results with the Ziehl-Gabbett stain certainly indicate the formation of spores. The threads in hanging drops are not motile.

CULTURAL CHARACTERISTICS.—1. *Blood Serum*.—The colonies form small, elevated, round, adherent dots of a golden-yellow color. The medium is not liquefied.

2. *Slant-agar*.—The colonies are simply small white adherent dots which later coalesce into a yellow membrane.

3. *Sugar-agar*.—The organism grows as a number of fine, elevated, brownish-yellow dots along the track of the needle.

4. *Potato*.—The colonies appear as fine dots which later form a yellow spreading membrane. The growth is very adherent.

5. *Milk*.—This medium becomes covered in one week with a thick yellow membrane, with elevations and depressions resembling a relief map. Litmus milk is rendered alkaline.

6. *Gelatin*.—Not liquefied. Colonies are fine, white, adherent dots.

7. *Dunham's Solution*.—A slight growth takes place in about five days, but no indol is formed even after two weeks.

8. *Nitrate Solution*.—After two weeks' growth in the nitrate solution a few colonies are present, and a slight nitrite reaction takes place.

FERMENTATION TUBE.—The organism does not cause gas formation in glucose, lactose, and saccharose bouillon, and does not grow in the closed branch of the fermentation tube.

In glucose bouillon in a flask the growth is very luxuriant, and in one week a white membrane forms on the surface of the bouillon. This later becomes wrinkled, and at the end of a month the surface growth has formed a number of round, knob-like elevations, varying in size from that of a pinpoint to a diameter of 3 mm. Some of these knobs are white, some are a dull golden-yellow, and a few show a combination of both of these colors. The colonies seem to need but little nourishment, as they even develop on the sides of the glass which has been moistened by the bouillon.

The development in glucose bouillon in the fermentation tube or flask might be considered as characteristic.

ANIMAL EXPERIMENTS.—A suspension of 2 cc. of the organism from serum was injected into the abdominal cavity of a guinea-pig, and the animal died in four days. The slight exudate consisted of small lymphocytes, large lymphocytes, polymorphonuclear leukocytes, red blood corpuscles, and endothelial cells. The liver contained a few dots

resembling tubercles. Cultures from the liver and peritoneal exudate gave a pure culture of actinomyces.

A rabbit was also given 3 cc. of a bouillon culture of one week's growth. The injection was made in the peritoneal cavity. The animal died in one week, and only a few yellow nodules containing actinomycetes were found scattered over the peritoneum. One white rat injected subcutaneously in the abdominal wall with 3 cc. died in ten days. There was a small caseous area at the seat of injection, and the organism was isolated from this area, but the viscera were sterile.

Another guinea-pig received 2 cc. in the abdominal cavity, and the animal died in twelve days. The report on the autopsy is as follows:

Guinea-pig; 3 cc. of bouillon injected in abdominal cavity on February 25. Died on March 9.

Body emaciated. Inguinal glands enlarged. The abdominal cavity was free from any exudate, and quite dry. In various places to be mentioned below, there were solitary, gray, firm masses about the size of a tubercle, which always projected from the peritoneal surface. These pseudotubercles were found on the upper surface of the liver, on the parietal peritoneum, in the shrunken great omentum, on the surface of the bladder, the gall-bladder, broad ligament of liver, posterior abdominal surface of lower sternum, and the diaphragm. Only from one to three pseudotubercles were found in each of these situations.

The thoracic organs and the other viscera seemed normal.

Cultures were taken from the abdominal cavity and the liver and actinomyces was recovered.

The last guinea-pig received an injection of 2 cc. directly into the pleural cavity, and the animal lived seven days. The result follows:

Thoracic Cavity.—The chest wall is deformed; the sternum, instead of being in the median line, is curved somewhat in the shape of an S, and has been thrust into the right mammary line. The anteroposterior line between the midsternum and the dorsal vertebræ is deflected to the right at an angle of 45 degrees.

The left pleural cavity contains some fibrinous adhesions binding the chest wall to the lung. The right pleural cavity in its posterior portion contains 10 cc. of a thick bloody fluid. The entire dorsal curve of the vertebræ is deflected to the left, having lost most of its anteropos-

terior curve. The entire parietal and diaphragmatic pleura on both sides, especially in the intercostal spaces, contains numerous gray, pinpoint areas resembling tubercles.

Lungs.—Both lungs are compressed, and their surfaces are covered in places with thick patches of yellow membrane. This fibrinous inflammation has also invaded the mediastinum as thick conglomerate pseudotubercles, and these grayish dots can also be made out on the parietal layers.

Lung Tissue.—The lung on cut section is congested and contains many grayish, pinpoint pseudotubercles; the right lung presents a similar appearance.

Abdominal Viscera.—The abdominal viscera are normal, with the exception of the liver; this contains a few yellow areas which look simply like distended vessels.

Microscopic Examination.—One of the pseudotubercles from the mediastinum on being teased out consists principally of cells with large, round nuclei surrounded by granular protoplasm often containing fat-drops. There are also small lymphoid cells, and few kite-shaped or spindle cells. Here and there can be made out typical branching threads stained by Gram's method.

Gall-bladder.—Gall-bladder contains many red blood corpuscles.

The cultures from the heart, kidney, and liver and lung tissue are sterile on blood serum and agar. The cultures from the pericardial cavity and both pleural cavities on blood serum and agar contain numerous typical colonies of actinomyces. The colonies on serum are of a golden-yellow color. These colonies, examined under the microscope, are typical examples of actinomyces, staining by Gram's method. It will be seen that this organism when injected into animals caused local nodules, either on serous surfaces or in viscera, which had a tendency to undergo necrosis.

DESCRIPTION OF THE MICROSCOPIC CHANGES PRODUCED IN HUMAN BEINGS AND EXPERIMENTAL ANIMALS.—In the cases reported by Eppinger, MacCallum and myself the lesions in human beings simply consisted in a purulent exudation respectively in the brain and meningeal cavity, in the peritoneal cavity, and in the air cells of the lung. Aoyama and Miyamoto found fibrinopurulent pleurisy and an abscess of the right lung.

When the organism was injected subcutaneously in animals an abscess usually resulted, but when introduced into the general circulation or into any of the serous cavities a large number of small granulomata or so-called pseudotubercles were produced. These lesions thus differ from those described in human beings.

MacCallum has made a very careful study of the histogenesis of these lesions by studying the early changes in animals (in two rabbits) killed four and six hours after inoculation. The capillaries of the lungs were crowded with leukocytes. This was the first response to the presence of *actinomyces asteroides*. The lung of an animal killed twenty-four hours after inoculation already contained small nodules consisting of widely distended blood vessels surrounded by alveoli, and their lumina were richly infiltrated with leukocytes. These nodules later undergo extensive necrosis, which process is the later result of the presence of the organism. These nodules never coalesce into larger distinct abscesses or cavities.

I was not able to confirm the early lesions described above, since I only examined animals that died at a much later period; but in such animals numerous necrotic pseudotubercles were found in the lungs, liver, kidneys, heart muscle, and on the surface of the various serous membranes. MacCallum did not find the typical production of lymphoid and epithelioid cells which precede necrosis of the true tubercle, due to *B. tuberculosis*, but he found that the connective-tissue cells proliferate later and form a capsule of granulation tissue, which often contained giant cells. Our own experimental lesions often showed a similar proliferation of connective-tissue cells, in which small lymphocytes were often present. The photomicrographs show the various proliferating cells and the necrotic pseudotubercles in the lungs and heart.

Actinomyces asteroides thus produces a primary exudation of leukocytes, and, of course, organisms from the capillaries. In rabbits and guinea-pigs this is followed by necrosis and encapsulation of the injured tissue by a proliferation of the fixed tissue cells.

Actinomyces Vesicæ.—Through the kindness of Prof. Hugh. H. Young, of Johns Hopkins University, I am also able to report an organism which he isolated by aspiration of the bladder in the case of a man, aged sixty years, at the Johns Hopkins Hospital.

The patient was suffering from chronic nephritis and uremia, with retention of urine. About 1500 cc. of urine were aspirated from the bladder, and much pus found in this fluid. In addition a bacillus which could not be identified as any pathogenic organism was isolated, and an organism with long threads and true dichotomous branching was isolated in pure culture. Its main characteristic is the brilliant orange color that it produces in cultures, but it can be distinguished from the actinomyces asteroides by the fact that it liquefies gelatin, casein, and blood serum. It did not prove pathogenic when injected into guinea-pigs, either subcutaneously or in the pleural cavity, and it cannot be claimed that it caused the cystitis noted above. It is probable that it did, however, since a saprophytic bacillus was the only other organism found in the purulent urine, and it is embraced in this study with the expectation that it may be noted in other pathogenic processes.

CLASSIFICATION OF THE VARIOUS SPECIES OF ACTINOMYCETES.—On reviewing the literature concerning the various species of pathogenic actinomyces it became apparent that several of the species described by different authors could be grouped as one species on account of their similarity. A few of the organisms have not been described completely enough for classification, but those which have been thoroughly described can be grouped as seven distinct species.

Actinomyces bovis can be distinguished from four of the other species by its failure to infect small laboratory animals, and from actinomyces Maduræ by the failure of the latter to liquefy blood serum or gelatin. The anaërobic species, actinomyces Israeli, can be distinguished from all other species by its preference for an anaërobic medium, and especially from actinomyces bovis by its production of necrotic pseudotubercles in guinea-pigs and rabbits. Actinomyces asteroides can be easily separated from actinomyces bovis by the failure of the former to liquefy blood serum and gelatin, by its bright golden-yellow appearance, and by the production of pseudotubercles in laboratory animals. It also differs from actinomyces Nocardii in its yellow color, and in producing an alkaline reaction in milk, while the latter remains neutral and white. Actinomyces Maduræ differs from actinomyces capræ by the former's failure to infect small laboratory animals, by the rose color of the

former, and the brown color of old cultures of the latter, and by the liquefaction of casein by actinomyces *Maduræ*. Practically all of the species described can be placed in these seven groups.

CHEMICAL PRODUCTS OF ACTINOMYCES ASTEROIDES.—MacCallum attempted to produce a soluble toxin from cultures in bouillon about three weeks old. These were filtered through a Pasteur filter, and the filtrate, in doses of from 6 to 10 cc., was injected into rabbits without any ill effects. The writer grew this organism for one month in neutral bouillon and then filtered it through the Pasteur filter, and preserved this fluid by 0.5 per cent carbolic acid.

Two guinea-pigs, weighing about 300 grams, were injected with 0.5 and 0.1 cc. of the fluid, and they died in ten days. The lungs were congested, and microscopic examination showed intense congestion of the lungs, liver, and kidneys. Two more guinea-pigs were injected with 0.1 cc., and one died in twenty-four hours. The seat of injection, the liver, and the lungs were all congested. The other pig remained well.

These experiments indicate that the organism forms a soluble poison for guinea-pigs.

CONCLUSIONS.—The various forms of pathogenic actinomycetes can be classified at present as seven species, which produce suppuration or necrotic pseudotubercles in man and various animals.

The generic name for this group should be actinomyces, since the other names have been previously used for other organisms.

Cases resembling tuberculosis but failing to show tubercle bacilli should be carefully examined for the presence of actinomyces.

In concluding, I desire to thank Mr. John Johns and Dr. John S. Fulton for the photomicrographs, and Dr. Caleb Rohrer for assistance in the pathological study.

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COALTON, W. VA., June 10, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find one dollar for the JOURNAL. The JOURNAL always receives the same consideration as a letter from home. It is the one link that binds the boys together.

Since graduation, I have been physician to the Davis Colliery Company, and Dame Fortune is smiling upon me. I have had better success than I had hoped for. I have seen very little mention of the boys of '06; what are they all doing? Dr. A. C. Blair, '91, is located in this town and is doing well.

With best wishes for the C. P. and S., I am,

Fraternally yours,

S. G. MOORE, '06.

PRINCETON, MASS., June 4, 1907.

Dear Dr. Brack.—The JOURNAL is always welcome, especially the personals. I have found many things in it which have been of great use to me in a rapidly growing practice.

Yours truly,

ELISHA SEARS LEWIS, '06.

WILLIAM S. GARDNER, M. D., EDITOR,
6 W. Preston Street.

JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., BUSINESS MANAGER,
500 E. Twentieth St.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE ANNUAL MEETING.

The annual meeting of the Alumni Association was held at the college in the large amphitheater Saturday, June 29.

The president, Dr. Jas. G. Riddick, mayor of Norfolk, presided and opened the meeting by an appropriate address to the visiting alumni and the present graduating class, paying a warm tribute to the memory of those members of the faculty, whom death has called away and giving words of good advice to those new members of our association who are about to enter into the field of practice.

Dr. Riddick then introduced the orator of the occasion, Dr. Britton D. Evans, the well-known alienist of Morris Plains, N. J.

Dr. Evans held the attention of the meeting by an extremely able and interesting address upon the subject of "The Physician in Court."

Dr. Evans not only quoted the scriptures to find his early expert witness, but illustrated his subject by citing many amusing anecdotes and many instances in his personal experience in the capacity of expert medical witness.

His address was received with much enthusiasm and a rising vote of thanks was tendered Dr. Evans by the Association.

The regular business of the meeting was then taken up and the officers nominated for the ensuing year.

Dr. Britton D. Evans was nominated by Dr. Chambers for president. The nomination was seconded by Dr. Chas. W. Birdsall, '85, a former

classmate of Dr. Evans, in a neat address in which he reviewed the achievements of the president elect, and called attention to his distinguished career and present standing in the medical profession as one of the best known alienists.

Dr. Evans was unanimously elected president; Dr. W. M. Garrison was elected secretary; Dr. Chas. E. Brack, treasurer; Dr. H. H. Esker, first vice-president, and Dr. H. S. Jarrett, of Towson, second vice-president.

The president appointed as executive committee, Dr. Standish McCleary, chairman; Dr. H. M. Cohen, and Dr. J. H. Hartman.

The publication committee consists of Dr. Wm. S. Gardner, editor, Dr. John Ruhrah, associate editor, and Dr. Chas. E. Brack, business manager and treasurer.

Dr. Brack reported as treasurer a balance from previous year of \$20.44; collections, \$759.75; expenditures, \$722.57, and a balance in the treasury of \$57.62. The class of 1907 was elected to membership in the association. No further business, the meeting adjourned to the lower lecture halls, where a lunch had been prepared, and the alumni lunched, smoked, and reminisced until late.

THE BANQUET.

The annual banquet was held at The Rennert immediately after the commencement exercises at the Lyceum.

Dr. Spencer M. Free was toast-master and in his element. He introduced the speakers in the happy vein peculiar to Spencer M.

Dr. Bevan, in most interesting manner, reviewed briefly the growth and development of the college, the present status of medical education and the medical colleges, and emphasized the need of a strong, active, and working alumni association.

Dr. J. W. Simpson, in a bright and cheerful way, touched upon our friendly and close association with the University of West Virginia and spoke of the need of maintaining the high standard of efficiency of the past and present.

Dr. McGlannan responded to the toast of the alumni association. Mac is budding into an after-dinner speaker of no small merit.

Dr. Okey R. Davis, representing the class of 1907, delivered a star

address. Dr. J. E. Sawtell, '86, of Kansas City; Dr. David Streett, '78, and Dean of the Baltimore Medical College; Dr. Chas. G. Hildebrand, '81, of Logansville, Pa.; Dr. C. Emmert Stuart, '87, of Pittsburg, Pa.; Dr. Thos. Lynch, '81, of Leonardtown; Dr. R. K. Palmerton, '81, of Cannonville, N. Y., and others, responded to the call of our toast-master and related many interesting and amusing anecdotes of former days.

Dr. McGlannan had mounted his Pegasus (for he is a poet as well as after-dinner speaker) and composed a number of verses, which were sung with much gusto to the air of popular melodies.

We sang Auld Lang Syne in the small hours of the morning.

Many of the visiting alumni and members of our faculty met again at Atlantic City the following day. All of our alumni, who can possibly do so, should not fail to attend the meetings of the American Medical Association. Those who do not cannot appreciate the advantages obtained by attending, nor the pleasure and enjoyment of associating with former classmates and old friends. This is especially true under the favorable conditions offered by Atlantic City as a meeting place.

We will endeavor to have a definite headquarters for the P. and S. at the meeting of the A. M. A. in Chicago.

The following alumni attended the annual banquet given to the graduating class: Spencer M. Free, '80; D. C. Mock, '04; Thos. Lynch, '81; S. J. Watermorth, '93; W. A. Gordon, Elkton, Va.; J. E. Sawtell, '86; E. F. Smith, '05; C. Emmert Stuart, '87; L. E. Wolfe, '91; Chas. G. Hildebrand, '81; Ben Coe, '95; David Streett, '78; Pearl Williams, '96; W. T. Riley, '90; Richard Gundry, '88; W. C. Johnson, '87; L. J. Gallup, '98; R. K. Palmerton, '81; Jno. S. Morris, '04.

A CORRECTION.

In the last number of the JOURNAL we published an account of Dr. Latimer. Through an error the name of the author was omitted. We want to take this occasion to say that it was by Dr. Samuel Theobald, of Baltimore, a lifelong friend of Dr. Latimer. We also wish to thank Dr. Theobald for the article which has been read with such interest by the alumni.

THE ATLANTIC CITY MEETING.

There were fifty-nine alumni at the Atlantic City meeting and perhaps more. There were many informal reunions after the meeting, and on one occasion a group photograph was taken. There was also a very impromptu meeting at the Islesworth. This was arranged late one afternoon and word passed along by telling every one that happened along to come. The next time that the association meets at Atlantic City or any resort where there is a likelihood of a large number of the alumni coming, a meeting will be arranged and advertise so that all may take advantage of it. The following alumni were registered at Atlantic City. We shall be glad to hear if we have left any one out. Frank M. Lockwood, '93, East Orange, N. J.; A. M. Colcord, '93, (Carnegie Steel Co.), Clairton, Pa.; Wm. Edw. Fitch, '91, New York, (Gaillard's Journal); J. G. Simmons, '91, Westchester, N. Y.; Harry Friedenwald, '86, Baltimore, Md.; W. S. Blaisdell, '90, Punxsutawney, Pa.; F. W. Wilcox, '03, St. Petersburg, Fla.; H. H. Hayden, '92, Baltimore, Md.; A. Cotton, '96, Baltimore, Md.; Melvin Rosenthal, '91, Baltimore, Md.; C. Emmert Stuart, '87, Pittsburg, Pa.; S. J. Waterworth, '93, Clearfield, Pa.; C. Hampson Jones, Baltimore, Md.; Ben Coe, '95, Dixonville, Pa.; Spencer M. Free, '80, DuBois, Pa.; Otto Schaefer, Baltimore, Md.; A. C. Harrison, Baltimore, Md.; A. V. Piskorski, '02, Jersey City, N. J.; J. B. Boucher, '94, Hartford, Conn.; Chas. F. Blake, '93, Baltimore, Md.; Pearl Williams, '96, Providence, R. I.; Richard Gundry, '88, Baltimore, Md.; Lewis Gundry, '90, Baltimore, Md.; Alfred Gundry, '94, Baltimore, Md.; C. M. Grigsby, '93, Kaufman, Texas; H. P. Jack, '01, Canisteo, N. Y.; W. Webb, '04, Belmont, W. Va.; W. Lee Ellis, '06, Baltimore, Md.; Riley McCollum, '00, St. Marys, W. Va.; Wm. P. Spratling, '86, Sonyea, N. Y.; R. K. Palmerton, '81, Palmerton, N. Y.; H. G. Beck, '96, Baltimore, Md.; John Ruhrah, '94, Baltimore, Md.; W. S. Evans, '03, Columbus, Neb.; W. J. McCaw, '81, Providence, R. I.; J. E. Sawtell, '86, Kansas City, Mo.; H. G. Stetson, '95, Greenfield, Mass.; Sherman Voorhees, '93, Elmira, N. Y.; Julius Friedenwald, '90, Baltimore, Md.; Chas. E. Brack, '95, Baltimore, Md.; W. W. Babcock, '93, Philadelphia, Pa.;

J. R. Boyd, '93, Oakvale, W. Va.; Reid Hunt, '96, Washington, D. C.; A. S. Grimm, '85, St. Mary's, W. Va.; Wm. S. Gardner, '85, Baltimore, Md.; Jos. H. Branham, '79, Baltimore, Md.; C. Garra-brant, '86, Atlantic City, N. J.; A. B. Straight, '91, Bradford, Pa.; D. C. Trach, '91, Kreggs-ville, Pa.; W. J. Hunt, '91, Glenns Falls, N. Y.; Geo H. Peddle, '91, Perry, N. Y.; P. Lantz, '91, Alaska, W. Va.; S. W. Woodyard, '91, Greeneville, Tenn.; J. O. McReynolds, '91, Dallas, Texas; B. W. Stearns, '92, Binghamton, N. Y.; W. J. Matthews, '92, Johnson City, Tenn.; G. M. Linthicum, '93, Baltimore, Md.

REUNION OF CLASS OF 1879.

There have been a number of suggestions about a reunion of the class of 1879 at the next annual banquet. This would be a good time to have it and with the published list it would be very easy for a committee to arrange to have a splendid representation. Dr. Cole, of Roanoke, Va., and Dr. A. L. Chapman, of Tarentum, Pa., are interested in it and why should not they get the class together next year? The columns of the JOURNAL are open to the class to help them.

HOSPITAL APPOINTMENTS.

City Hospital: H. H. Esker, '06, Resident Physician; Walter D. Wise, '06, Associate Resident in Surgery; H. H. Theis, '06, Associate Resident in Medicine; H. A. Nicholson, '06, Resident Gynecologist; J. A. Miles, A. M. Sorrell, A. E. Winlack, F. W. Steiner, S. W. Merrill, Joseph G. Graver, Assistant Resident Physicians.

Maternite Hospital: J. K. Pepper, Resident Physician.

Bay View Hospital: A. W. VanKirk, E. A. Corbin, John A. Wiseman, Resident Physicians.

COMMENCEMENT.

The annual commencement was held at Albaugh's Theater Monday evening, June 3. The orator of the evening was the Hon. John Gill, congressman of Maryland. The diplomas were awarded by the dean,

Dr. Charles F. Bevan. Dr. Spencer M. Free, of DuBois, Pa., made the address to the prize men, and awarded the prizes as follows:

Everett R. Taylor, W. Va., first prize; Newton W. Smith, N. B., second prize; Alex. E. Winlack, Jr., Pa., third prize; George L. Mack, N. J., fourth prize.

Worthy of honorable mention were: S. W. Merrill, Me.; Warren D. Miller, Pa.; James J. Tynan, Conn.; Gilbert F. Buxton, Md.; D. G. Preston, Va.; Othon de Caturla, Cuba; J. A. Powell, N. C., and A. M. Sorrell, Mass.

SUGGESTIONS FOR REUNION OF THE CLASS OF 1893.

Dr. F. W. Lockwood has suggested that there be a reunion of the class of 1893 at the next Alumni Association banquet. This is a good idea and we should suggest that he and one or two other members of the class form a committee and take measures to get in communication with all of the survivors. We shall be glad to hear from any members of the class anent this proposition.

Dr. Harry Friedenwald, '86, Baltimore, and Dr. S. W. Woodyard, '91, Greeneville, Tenn., are members of the House of Delegates of the American Medical Association.

Obituary.

The following notice of Dr. William B. Graves, '01, is reprinted from of the DuBois papers:

The untimely death of Dr. William Bernard Graves yesterday afternoon produced a sensation of profound grief in many hearts and a shadow of gloom cast itself over the entire city, penetrating to many nearby towns. It was a severe shock to the city of DuBois and will be keenly felt by the people.

Dr. Graves' death came only after a bitter struggle extending over seven weeks, which was marked with the tender ministrations of loved ones and the best of medical aid. He died at 1.27 o'clock yesterday afternoon.

Death was due to typhoid fever, preceded by pneumonia. For weeks his condition was regarded as most critical and, while his death was not wholly unexpected, it came as a great shock to the entire community.

Dr. Graves was 34 years of age. He was born at Point Peninsula, N. Y., in the year 1873 and there grew from a boy to manhood. His heart leaned toward the study of medicine, and when a young man entered the College of Physicians and Surgeons, at Baltimore, Md. He graduated from this institution in the year of 1901 and at once became a resident physician in the Maternity hospital, of Baltimore.

The wide experience he thus gained admirably fitted him for the work he had mapped out and the following year he came to DuBois to become an assistant to Dr. Spencer M. Free.

Two years later he branched out for himself and inaugurated his brilliant career as a practitioner. An office was opened in the Deposit National bank building and it was but a short time before his marked ability as a physician won for him an ever growing practice.

In September, 1905, Dr. Graves was married to Miss Lillian Johnson, daughter of Mr. and Mrs. J. A. Johnson, of North Main street. A little son came about a year ago to bless the union, and the widow and child survive him.

Dr. Graves' parents are still living at the old homestead at Point Peninsula, N. Y., and one brother and two sisters are left to mourn his loss.

The deceased was a member of the I. O. O. F. and the B. P. O. E. and was faithful in the obligations of these orders. He was prominently identified with the growth of the city and held the interest of the people in general at heart.

His professional career was one featured with triumphs and achievements and one did not hesitate to call him in the most desperate of cases. He was charitable and spread sunshine and hope wherever he went. The eyes of hundreds looked up to him and they are the ones who will most keenly feel the sadness of his demise, and join with the entire community in extending heartfelt sympathy to the stricken home.

Personal Notes.

SOMEONE has passed the word along that there are good openings for a physician at both Monterey and Wayne, Schuyler county, New York. We do not know anything about these openings but they may be worth looking into.

DR. J. A. GUTHRIE, '03, now located at Huntington, W. Va., spent the month of April doing post-graduate work about the Hospital and College.

DR. JOHN H. SPYKER was a visitor about the College in June. He is now located at Decatur, Illinois, and has offices in the Millikin building at that place. He is examiner for the Northwestern and Manhattan Life Insurance Companies and at present is surgeon to the Marsch-Atlas Construction Company which has on hand large grading contracts on the Wabash road.

DR. T. A. POOLE, '97, who has been for a number of years at Nassau, N. P., has opened an office at 203 North Eutaw street in Baltimore.

DR. A. C. CRAWFORD, '94, has a fine position with the government doing research work.

DR. G. DAVID, '80, died at Sidney Centre, N. Y.

DR. J. B. MCGRAW, '83, died at Pittsburg, March 16, aged 52.

DR. JOHN LAWRENCE RYAN, '92, of Malden, Mass., died from tuberculosis recently in Calumet, Mich., after an illness of two years, aged 38.

DR. CHARLES DANIEL CRISTMAN, '86, of Wiconisco, Pa., died in a hospital in Philadelphia, June 8, after an operation for cholelithiasis, aged 50.

DR. WILLIAM A. KLESA, '96, died in Sweeden Township, Potter county, Pa., recently, from tuberculosis after an illness of two years, aged 35.

DR. WILLIAM RODES, '76, of Lexington, Ky., who had suffered from rheumatism for the last four years and had spent his winters in Clear Harbor, Fla., died suddenly at that place, May 14, from rheumatic endocarditis, aged 56.

DR. JOHN H. WENGERT, '79, formerly a practitioner of Fredericksburg, Pa., died suddenly at his home in Windber, Somerset county, Pa., May 12, from heart disease, aged 49.

Correspondence.

INDIANAPOLIS, IND., June 28, 1907.

DR. CHARLES EMIL BRACK, Baltimore, Md.

Dear Doctor.—Have regularly been receiving the JOURNAL which you have kindly sent me, and enjoy same very much. If you will advise me what I owe you, will remit at once.

I see where you ask for information regarding the whereabouts of a number of the old boys, including Tetty Crosby. I have heard that Crosby was in Mt. Clemens, Mich., and as I want to see him personally I will run up there in the next week, and if I am successful in locating him will advise you.

Have been doing very well here in general practice, but am going abroad this winter to take up the speciality of eye, ear, nose, and throat.

Remember me to all my friends there, and with best wishes for yourself, I beg to remain,

Very truly yours,

XENE Y. SMITH.

BISHOP, ARIZONA, April 10, 1907.

MR. R. ANNAN.

My Dear Friend.—I was pleasantly surprised when I received the signed card with your kind note enclosed. Now to tell you all about what has happened to me since I left the hospital. I came out here to Arizona and accepted a contract position with a big mining company, and got a fair salary, and in addition picked up a fine practice on the side. I was doing remarkably well when my folks induced me to go to New York, claiming that they had a "good thing for me." They then prevailed upon me to start in Connecticut, which I did, and after a few weeks decided I didn't like the place and quit. I then came back to Arizona (in November) and am here practicing now. Of course I had to begin all over again, but I am gradually picking up a fairly good practice. I am glad Mr. Albert still remembers me and I hope you will not forget to convey my kindest regards to him. I am enclosing a check for the Alumni Association JOURNAL, and if you

will hand it to Dr. Brack with the request that he send me the JOURNAL, I will be very grateful to you. I have not received the JOURNAL for nearly a year, so please hand him my address. Thanking you in advance and hoping to hear from you soon I remain with kindest regards,

Your friend as ever,

M. D. COHEN.

DARLINGTON, S. C., April 27, 1907.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Find enclosed \$2.00 (postal note) for past subscription to the JOURNAL of the Alumni Association. I have not visited the beautiful and hospitable city of Baltimore since I left the walls of College of Physicians and Surgeons in '79, save passing through "en route" to New York to take Pasteur treatment, having been bitten by rabid dog. I have had many and varied experiences in my medical career. Some very trying ones. I notice my name appears in the January issue of the JOURNAL, class of '79, making 27 years that I have been in the "harness." A sufferer from rheumatism, work, and worry, I am somewhat disfigured, "but still in the ring."

It was with sorrow and regret that I have been apprised of the death of some of our noble professors, such as Rhoe, Latimer, and others.

I have a beautiful farm of several hundred acres on which I live, and practice my profession in the surrounding country.

Most truly yours,

JOHN P. PARROTT, '79.

WARM SPRINGS, MONTANA, May 27, 1907.

Dear Brack.—I think you would be interested in knowing how many P. and S. men are in our State. They are drifting west. Dr. O. Y. Warren, R. L. Stokes, A. C. Biddle, and Dr. Mathews are in Butte. Dr. Lines, '84, is at Columbus, Mont., and W. W. Deal, H. G. Morgan, and myself are here at the Springs. Four of us attended the recent Montana State Institute at Billings, with Dr. Warren as president.

Best regards,

SCANLAND.

WASHINGTON, D. C., May 22, 1907.

Dear Doctor Brack.—Enclosed find some tonic to stimulate the JOURNAL for another year. Am always very much interested in the personals.

Of the boys of '96, J. M. Walls is located in Naples, Texas, and is one of the leading practitioners of that thriving town. He is also incidentally interested in increasing the population of that State, and has honored me by naming the first born, Arnold.

W. Quinn is located in a mining town, Fayette City, of western Pennsylvania, has charge of the miners, gets a very large salary, and has to employ an assistant.

Samuel Gregory is located in Mt. Union, Pa., and has an immense practice, besides large real estate interests. A fortunate deal in the latter line made last summer has placed Dr. Samuel on "easy street."

Dr. G. W. Boyd of class of '95 is still located in this city, and is one of the most successful practitioners of the Capitol City. His summers are spent at his cottage at Chesapeake Beach, Md.

J. M. Johnson of '96, is located at Huntingdon, Pa., and is doing very well. His original location had been at Coal Port, Pa., but the doctor outgrew that location and has settled where his opportunities will not be restricted.

Dr. Jesse Coggins of the same class called upon us recently. He has a large private sanitarium at Laurel, Md., and is busy and prosperous.

With best wishes I remain,

Yours fraternally,

J. S. ARNOLD.

BROOKLYN, N. Y., May 18, 1907.

DR. C. E. BRACK, Baltimore, Md.

Dear Doctor.—Please find enclosed dollar for my subscription to the JOURNAL. The April number just reached me with the subscription blank enclosed.

I am now located in Greater New York, Borough of Brooklyn, practicing largely among the "flaters" and doing very well financially.

Hoping to hear more of the "'03" boys through the JOURNAL, I am,

Very sincerely yours,

C. F. ABBOTT.

DR. CHAS. E. BRACK.

NEWARK, N. J., April 18, 1907.

My Dear Doctor.—In looking over an old bill file I came across the enclosed bill.

Enclosed you will please find check for four dollars (\$4.00) in payment of it, and the extra amount to be applied to subscriptions subsequent to the period covered by the bill.

Have lost track of most all the boys and the JOURNAL is my only means of possibly hearing of some of them.

Yours truly,

C. F. MURRILL, '02.

THE PATHOLOGY AND TREATMENT OF HAY FEVER.

One of the most striking pathological features of this malady is a turgescence of the turbinal tissues due to extensive dilatation of the capillaries. That this is the result of an angioneurosis, involving a more or less pronounced local vaso-motor paralysis, is pretty generally conceded.

In the treatment of hay fever with Adrenalin Chloride it has been suggested that weak solutions, frequently applied, are apt to yield better results than the occasional application of strong solutions. The application of the solution of Adrenalin Chloride stimulates the vaso-motor supply, resulting in a contraction of the capillaries. Overstimulation, by reaction, is very sure to result in a complete paralysis of the vaso-motor supply in the region affected. On the other hand, gentle stimulation with weak solutions is not so likely to be followed by a reaction.

Solution Adrenalin Chloride (1:1000) may be diluted with normal salt solution and sprayed into the nares and pharynx.

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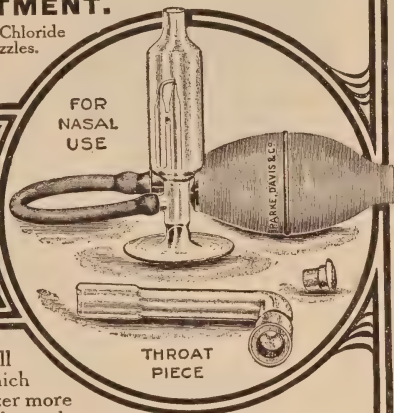
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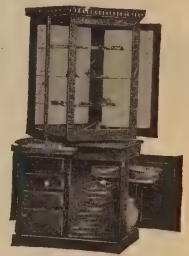


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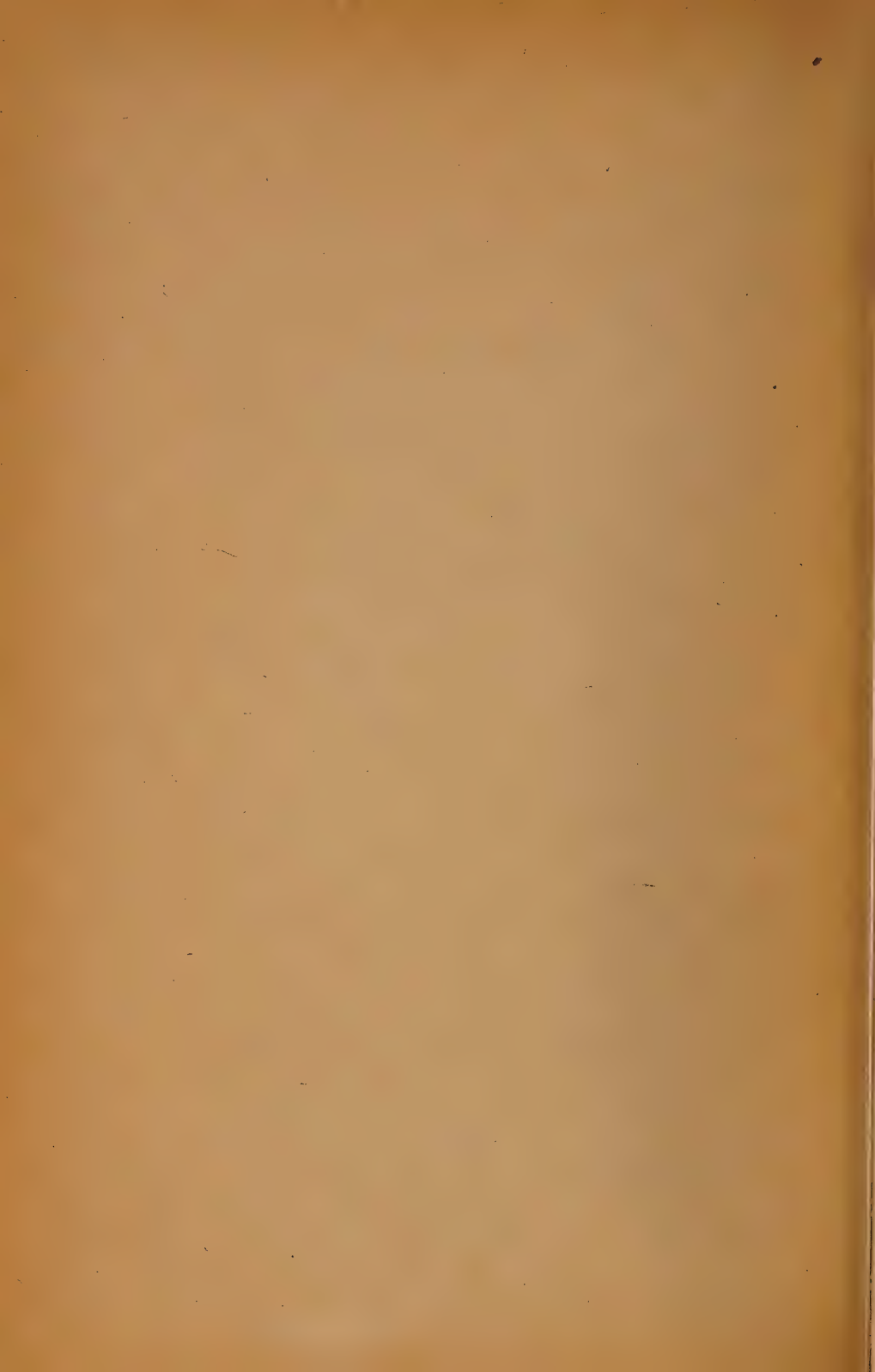
THE JOURNAL
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Vol. X

No. 3

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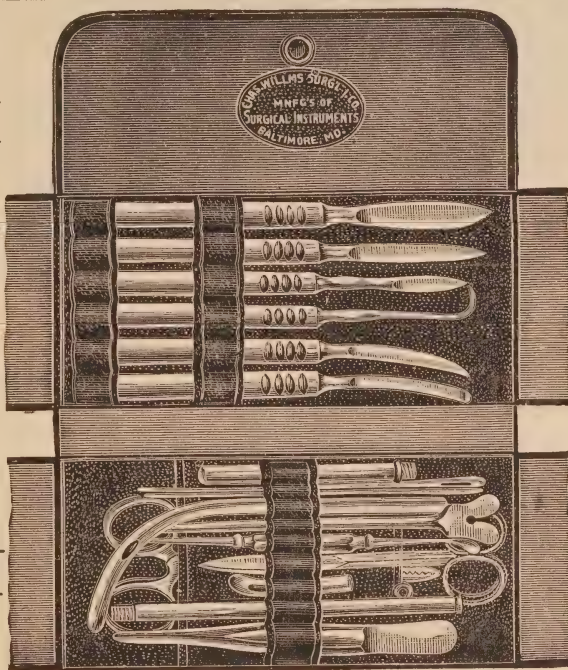
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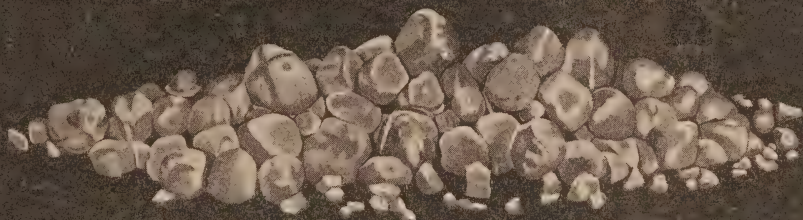
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THE DUTY OF THE PUBLIC TOWARDS THE TRAINED
NURSE.*

BY WM. ROYAL STOKES, M. D., BALTIMORE, MD.

Sister Superior, Gentlemen of the Faculty, Members of the Graduating Class, and Ladies and Gentlemen:

Although I am aware that it is usually the custom on such occasions as this to administer a few well chosen word of advice to the graduates, yet in this case I feel sure that such obligations to our graduating class have already been amply fulfilled.

A meeting of this kind, however, offers another opportunity to anyone disposed to accept it, and I have, therefore, chosen as my topic "The Duty of the Public Towards the Trained Nurse."

Before stating my views on this subject it may not be out of place to briefly trace the development of this noble profession. I shall, therefore, first mention a few of the chief events in the history of trained nursing.

It has been well said that the profession of nursing began with the Christian era. Before this time certain Jewish women were organized into societies for caring for the sick, and the Druids of Gaul had women who nursed ill persons. These well-disposed persons were sometimes considered to be witches, and were destroyed by fire and other forms

* Read at the Graduating Exercises of The Training School for Nurses at the City Hospital, June 18, 1907.

of execution. The profession thus became rather unpopular, and finally disappeared.

The system of trained nursing seems to have received a great impetus from St. Paul and the Acts of the Apostles, and the Epistles contain accounts of many devoted women who gave up much of their time to nursing the sick. These women combined the duties of the religious teacher, the social worker, and the trained nurse in one profession. Dorcas, "This woman full of good works," and "Phoebe our sister," commended by St. Paul, with many others, must have often ministered to the sick in that interesting community of the early Church.

St. Paula, a noble lady of Rome, being left a wealthy widow, gave both her money and time to nursing during the fourth century at Rome, and later at Bethlehem she organized an order which cared for sick pilgrims.

Such communities were soon recognized as most beneficial, and about 660, A. D., the Hotel Dieu was established at Paris as a large hospital. The hospital sisters, or "Soeurs Hospitalieres," performed the office of nursing in this institution, and Sarah Tooley, in her "History on Nursing," tells us that they remained for 500 years the only organized nursing sisterhood in a large hospital. Thus the idea of trained nursing was kept alive through the centuries. In the first school for trained nurses, established by the Abbess Hildegarde, near Bingen-on-the-Rhine, the nuns were instructed in the use of drugs. They also obtained practical work in the convent infirmary, established for the poor. The Knights Hospitallers, or Knights of St. John, established a hospital in Jerusalem, in the eleventh century, to care for the sick pilgrims, who often reached the Holy City ill and poor, or wounded by the robbers on the way. The ill treatment of these pilgrims led to the various crusades. The Knights of St. John soon became a fighting organization, and took part in many battles for the defense of the Holy Land against the Mahometans. They formed an organization of brothers and sisters, who nursed the sick and homeless in St. John's Hospital, at Jerusalem. Hospitals were also founded in many European and Asiatic cities, along the routes of pilgrimage and this powerful society remained for centuries the great hospital order of Europe.

We cannot approach modern times without mentioning the splendid

work of Saint Vincent de Paul, the shepherd boy, who became one of the most famous priests and philanthropists of his time. In 1617, at Lyons, he organized his well-known order of Sisters of Charity, which at Paris in 1633 developed into the Sisters of Saint Vincent de Paul. Many rich and famous women joined this order, and in twenty years over 200 homes and hospitals belonging to this organization had spread over Europe. They not only nursed the sick in hospitals, but were expected to care for the suffering in every town and every land. A modest dress and headgear were designed, and the good, old saint showed his knowledge of the eternal feminine, when some of the more worldly suggested that the dress might be changed to suit different places. "No," said he, "they will have as many different hats and bonnets as there are cities and countries." And so to-day the ever-welcome garb of the sister of charity is the same "in Greenland's icy mountains" as "on India's coral strands." From now on we have the nurse visiting the sick in their homes, and this order has founded over 2000 houses, with many hospitals, orphanages, and schools throughout the world. This society also brought the trained nurse out of the cloister and hospital into the outside world, and thus greatly broadened the scope of such humanitarian work.

It is hardly necessary to mention the nursing sisters of the twelfth century attached to St. Bartholomew's and St. Thomas' Hospital, in London, since they were driven away with the general dissolution of the monasteries by Henry VIII, in 1525. Nursing in England received its quietus for several centuries, and was only revived by the epoch-making struggles of Elizabeth Fry. This energetic woman was born in Norwich, in 1780, and her family had been Quakers for generations. After a girlhood spent in frivolous pursuits, she began earnest philanthropic work, and accomplished many important prison reforms. In 1840 she visited Pastor Fliedner at Kaiserswerth, and became so much impressed with the training school for nurses at the Deaconess Hospital that she took steps, upon returning to England, to establish a religious institution for training nurses. These nursing sisters lived in a special home, but were trained in the hospitals. When their probation was over, they were allowed to nurse in hospitals or private homes, and received remuneration according to the ability of the patient or family. They

were all compelled to spend part of their time in the gratuitous nursing of the sick.

Most of us have doubtless enjoyed the humor of Dickens, as expressed in his character of Sairey Gamp.

“‘Mrs. Gamp, if ever there was a sober creetur to be got at eighteen pence a day for working people, and three and six for gentle folks, you are that person.’

“‘Mrs. Harris, I says to her, don’t name the charge, for if I could afford to lay all my fellow-creeturs out for nothink, I would gladly do it, sich is the love I bears ’em.’”

These character studies in Martin Chuzzlewit focussed public attention upon the crudities of nursing and helped to advance the profession to its present well-organized condition.

Many important advances followed this arousing of public sentiment. King’s College Hospital, in 1856, instituted a training school for nurses, and admitted the sisters of the famous St. John’s House to training. The conditions revealed in the hospitals at this time were serious, although not without their humorous side. Nurses of the Sairey Gamp type were frequently dismissed for drinking the patient’s brandy, wrapping up in a patient’s blanket for a quiet nap at night, returning to the ward at night drunk and disorderly, and for many other graye breaches of discipline and morals. Imagine, young ladies, if you can, the tapman from the neighboring bar room passing through your ward twice a day, to receive your order for ale, porter, or brandy. These and many other bad practices were stopped when training schools were added to the large London hospitals. Contagious diseases were separated from non-contagious conditions, baths and open windows were introduced, and sick diet became a regular part of treatment in the wards.

In a consideration of the evolution of trained nursing the work of Pastor Fliedner cannot be omitted. This Lutheran clergyman, after many severe struggles succeeded in establishing a small hospital at Kaiserswerth, a village on the Rhine, in Germany. The nursing was carried out by deaconesses, and from this small “Mother House” with two deaconesses and one patient a system developed which included one hundred similar institutions in all parts of the world. Kaiserswerth, in addition to a large hospital and training school for nurses, also soon in-

cluded an orphanage, a school for girls, a female house of refuge, a normal school, and many other philanthropic institutions. It has furnished thousands of nurses to many hospitals in all parts of the globe, and its most famous pupil was Florence Nightingale.

Miss Nightingale was born near Florence in 1820, but spent most of her time in England, where her family had lived for generations. Her life as a girl and young woman at Lea Hall and Lea Hurst in Derbyshire was filled with many charitable deeds, and she became very much interested in the hospital system in Great Britain. While carrying on these investigations, she met Elizabeth Fry, who persuaded her to visit Pastor Fliedner at Kaiserswerth.

This well-born and highly cultivated young English woman entered Kaiserswerth Hospital as a nursing deaconess, when many considered such work beneath their dignity. She endeared herself to all about her, and left the institution after a thorough course in hospital nursing. After studying with the Sisters of St. Vincent de Paul, in Paris, she returned to England, and immediately began a life of philanthropy in London. Here she helped to organize schools for poor boys, children's hospitals, emigration bureaus for poor women, homes for sick governesses, and other similar institutions.

In 1854, the Crimean war began, and from the very centre of this struggle Florence Nightingale received the call for her life work. Although victory followed the English arms, yet the enthusiasm of conquest was tempered by the news of the frightful condition of the sick and wounded. Food, clothing, medicines, bandages, and other necessities were all wanting. There were not enough physicians, and no nurses for the English soldiers. It was at this time that the "one clear call" came for Florence Nightingale. Russell, the war correspondent, wrote: "Are there no devoted women among us, able and willing to go forth to minister to the sick and suffering soldiers of the East. . . . Must we fall so far below the French in self sacrifice—in a work which the Master so signally blesses as done unto Himself? 'I was sick and ye visited me.'"

Miss Nightingale immediately responded, and organized her celebrated band of nurses for the military hospital at Scutari, near Constantinople. This band consisted of fourteen Church of England sisters, ten Catholic Sisters of Mercy, and fourteen nurses from various other sources.

The leader was made lady-in-chief, in charge of all the hospitals. Shocking conditions were found at these hospitals. No beds; men lying for weeks in uniforms still stained with blood from their wounds; no soap, towels, nor vessels for water; no kitchens, or culinary utensils, and no sheets, drugs, or medical supplies. Cases of cholera, of plague, of hospital gangrene lay side by side with the wounded on the floor of the hospital at Scutari. These conditions were slowly but surely remedied, but before peace was declared the lady-in-chief contracted hospital fever and nearly died. After the war was over she remained until most of the wounded were safely shipped to England.

The rest of the life of Florence Nightingale is intimately associated with almost every philanthropic reform in England, but one of the most important was the founding of the training school for nurses at St. Thomas' Hospital, in London, 1860. Other hospitals later followed suit, and the modern training school for nurses dates from this era.

If time permitted we would consider many other important reforms instituted by Florence Nightingale and her followers, but I can only mention the introduction of trained nurses into military and naval hospitals and institutions for the insane as due to her pioneer work.

The Poor Law Nursing Service was also greatly improved by the substitution of trained nurses for pauper, inmate, and feeble and aged attendants, and many cases of shameful abuse and neglect were corrected by the untiring work of Louisa Twining. The establishment of various associations for private nursing, the institution of district nursing, by Mr. William Rathbone, the struggle for registration of nurses, and the general recognition of nursing as a special profession are all interesting, but I must close this part of my subject with a brief consideration of our own workers in this cause.

It is customary to commend persons after their death, but I can see no reason why I may not mention the names of a few of our local workers while they are still with us. Due credit should be given to Miss Nutting for her admirable work in advancing our American profession of trained nursing, and she will still continue to add valuable contributions from her professional chair at Columbia University. Miss Ross is ably continuing her work at the Johns Hopkins Hospital, and Miss Flanagan, of the University Hospital, and many others are helping to

elevate the standards of this profession in Maryland. I cannot close this subject without expressing my great respect for the work of two other women in our community: one the life-long friend of my grandfather, and the other, I hope, my own. I refer to Sister Catherine, of Mt. Hope Retreat, and Sister Carmalita, the Sister Superior of our City Hospital.

And what do we owe to this profession, and to these women? I shall answer with brutal frankness. We owe them money.

It is almost unnecessary to mention the various things which are needed in a large hospital. Beds endowed, new wards opened, instruments of special precision in these wonderful days of modern medicine, are all thoughts which at once arise. Pensions for disabled or sick nurses, libraries, special courses, and many other needs might also be recognized. Go and discuss these matters with a sister or trained nurse for fifteen minutes, and if you do not leave them with an empty pocket book, you are "Fit for treason, strategy, or spoils, let no such man be trusted."

But there is a special piece of work which especially commends itself to me at this time, and this is the reorganization of the out-patient departments or the dispensaries of our hospitals. The pioneer in this work is Richard C. Cabot, and his article in the *Maryland Medical Journal*, for March, 1907, describes the great work that he has accomplished in Boston.

He aptly emphasizes the present condition of affairs by the quaint quotation from "Alice in Wonderland."

"Have some wine," said the Hatter.

"I don't see any wine," said Alice.

"There isn't any," said the Hatter.

As Cabot says, we tell patients to get a new position, a vacation, an expensive splint, a change of climate; and we might as well tell them to get a million dollars. Like the Hatter, we invite them to have some wine, and there is no wine.

It seems to me that a general society called a dispensary society might well help to solve the many serious problems that arise in the various dispensaries. Representatives from all of the hospitals might accomplish more good in one large society, than smaller local organizations. Such a society, as pointed out by Cabot, by soliciting subscriptions might

furnish special workers and apparatus for many nervous cases, might provide for massage, and administer the hydropathic cures by skilled operators. They would follow many patients to their homes, perhaps remove serious sources of worry, and might save many lives by properly instructing consumptive patients in the prevention and cure of this disease. Proper cases would be sent to sanatoria for treatment, and district nurses could find many needy cases if directed from such central source. Patients with diabetes could be provided with proper diet, milk could be modified for children, and, in fact, the dispensary might be made a general clearing house for the alleviation of many grave and even minor ills.

In order to properly carry out these methods Cabot believes that a few skilled physicians and social workers should be paid for their work, as he thinks that this is just as important public work as that of the Department of Health, or Charities and Corrections.

He found that 37 per cent of the cases at the dispensary of the Massachusetts General Hospital were cases of purely functional disorders which might be better treated by the methods outlined above than by the wholesale and often useless drugging so prevalent at present in our dispensaries. Many organic diseases, such as tuberculosis in its various forms, and surgical diseases also, often need other aid than that of medicine or of the surgeon's knife.

But why continue this discussion any further. The kind hearts of the women here present have doubtless already solved some of these problems while I have been talking about them. Why not form such a society as I have merely briefly outlined? And why not use as its motto these words:

“And the greatest of these is Charity.”

PROSTATIC MASSAGE.*

BY DR. W. L. CHAMPION, ATLANTA, GA.

In a few words I desire to bring before this Association a comparatively recent adjunct in the treatment of deep-seated gonorrheal infection, that is indispensable in many cases, if a cure is perfected. This

* Reported from The Atlanta Journal Record of Medicine.

advancement is not original, but one that sufficient attention has not been called to, to lessen the number of infections, and gain the results in practice we all hope for. The profession as a whole will never be enlightened as to the serious nature of gonorrheal infection, and become so familiar with the disease that each and every member can knowingly inform a patient when he is no longer infected, or can safely marry. Still the work that has been accomplished within the past few years along this line—showing the large percentage of innocent women with acute pelvic troubles, due to the gonococcus, has opened the eyes of many, and it is to be hoped that in the near future, the men in our ranks, as well as laity, will not look lightly upon a disease that causes more suffering than tuberculosis or syphilis. A statement of this kind may be looked upon as a joke, or flippantly dismissed, but any gynecologist of experience, or genito-urinary surgeon, will bear out the assertion.

The careless manner in which gonorrhea is treated and dismissed by many practitioners is a stumbling-block to more rapid advancement in the treatment, and in a measure to the suppression of this disease. When the profession looks upon gonorrhea as a disseminator of infection, and endeavors to suppress the disease and limit its number of victims, as we would diphtheria or small-pox, then we will be on a sound basis to accomplish a great deal more than is being done at present. The large number of men with deep-seated gonorrheal infection who are considered well, or told they are as well as they will ever be, not knowing that dangerous elements lie hidden or dormant in the prostate, prompted the foregoing remarks.

“The prostrate gland is a sexual organ, partly glandular, partly muscular, lying in front of the bladder about the prostatic urethra. The prostate is the sexual heart. It has nothing to do with urination, and is quite passive during that act. But towards the sexual function it acts as a muscle, a sensory organ, and a gland.” This gland when involved by extension of urethral infection is relievable by prostatic massage properly applied. This does not apply to prostatic hypertrophy of old age. The relation of the prostate to the urethra makes the former more susceptible to infection than other adjacent structures. As a rule in patients that are told they have a gonorrheal cystitis, the prostate

is the seat of the trouble. Many of the stubborn cases of gonorrhea, with profuse discharge, and those with only "clap shreds" in the urine, which will not respond to injections, irrigations, and the use of the sound, remain uncured because the prostate is involved, and the proper measures to give relief have not been instituted. One of the best friends and most frequent visitors to the doctor is the patient with chronic gonorrhea of years' standing, who will go for months apparently well, and a night out with a friend, and a few bottles of beer, produce a return of his old trouble. This condition in a vast majority of cases is due to an infected prostate, that is not cured by injection, irrigation, or the sound, which only relieve the acute condition until the exciting cause reproduces the same results. The presence of a urethral stricture of large calibre, or the endoscope showing a granular urethra does not necessarily mean that the relief of this condition perfects a cure. When the stricture has been cut, and the endoscope shows the urethra no longer granular, yet still we have pus in the urine, then we must look elsewhere for the trouble; and usually it will be found in the prostate. Now, I am not condemning the use of injections, irrigations, or the sound, for they all have their place, but only pointing out the value of prostatic massage in deep-seated gonorrheal infection. The relief given to an extremely nervous patient, with vague pains in the pelvis, back and limbs, with a dull, heavy sensation in the rectum, after carefully massaging his sensitive and swollen prostate, is sufficient evidence of the value of the procedure. At the next visit, the first exclamation of the patient is, that you have located the trouble and he feels greatly benefitted. Also the marked improvement in the condition of the urine after the first treatment is very noticeable.

There are various positions in which patients are placed to examine and massage the prostate. I have the patients stand with elbows on seat of a chair, legs straight and feet separated. Use pressure over bladder with left hand, and massage prostate with fore-finger of right hand. The use of the rubber finger-cot makes the treatment less objectionable to the patient and more cleanly to the surgeon. The finger should be passed up to the base of the prostate, and pressure made as the finger is brought towards the apex. Firm pressure should be made over the

entire gland, noting the impression made upon the patient. If he becomes faint limit the examination or massage to a few seconds and make a more thorough massage at the next treatment, when the patient will tolerate more pressure upon the gland on account of a less sensitive condition, due directly to the previous massage. In highly nervous individuals, or those in whom the gland is very sensitive, massage every fourth or fifth day is as often advisable. In some cases I use massage only once a week, while in others, with urine cloudy, dull, heavy sensation in gland, with frequent desire to urinate, I massage every second or third day, if the patient is made more comfortable by such treatment. The amount of pressure made upon the gland, the intervals between the treatments and the length of each séance, must be determined by results obtained in each individual case. When a prostate is massaged, instruct the patient to save some urine in the bladder, so that after the treatment the urine can be voided in a glass, so as to note what secretion is compressed out of the gland. Always irrigate the bladder after massage with an antiseptic solution, so as to cleanse it of any septic material that may be present. Stones or concretions in the gland should be felt for, the condition of the vesicles and any nodules or other abnormalities noted. The vesicles are above the prostate, and lie on the outside of each vas deferens. Stripping of the vesicles is necessary to remove gonorrheal infection, and the genito-urinary surgeon is called upon to determine if the patient is sterile, by obtaining the semen to note if spermatozoa are present and alive. By massage of the prostate we compress out the infected secretion and stimulate circulation in the gland and adjacent diseased structures. Where there is a spasmodic condition of the neck of the bladder and deep urethra, massage relieves the sensitive condition and spasm, so that the patient is made more comfortable, and irrigation of the bladder is more easily accomplished. To illustrate that sensation is blunted, it is noticeable that a patient can not empty the bladder immediately after massage. Lydston has well said that "sexual neurasthenia, embracing bowel inactivity, melancholia, hypochondriasis, and that seldom recognized but frequent condition, male hysteria, are among the results of chronic prostatic disease which are frequently relieved by proper and systematic massage."

A frequently obscure condition, but one due to a local irritation, abnormal nocturnal emissions and premature ejaculation, are frequently benefited or relieved by massage. I recall a case I had a few months ago, of a boy sixteen years of age who had wet the bed every night since his birth, and a single massage caused him to pass a week without wetting the bed.

While prostatic massage is indicated in deep-seated infection due usually to gonorrhea, I mention these conditions to show the correcting influence it may have on other irregularities. This measure is not a cure-all; it is a recognized procedure that will relieve some heretofore obscure diseased conditions of the genito-urinary apparatus.

ADENOMYOMATA OF THE UTERUS.

By DR. EUGENE KERR.

It is only in recent years that this variety of uterine growths has received extended attention. A review of the literature on the subject finds half a dozen articles in English journals.

Von Recklinghausen is the authority whom all writers give credit for bringing the subject to the front and for giving it extended study. He is of the opinion that adenomyomata originate from the epithelial remnants of the Wolffian body, as the glands which are found in these myomata correspond in their arrangement and structure to the structure of the glandular elements of the Wolffian body, point for point. As regards the relative dependance of the glands and the muscle tissue in these adenomata V. Recklinghausen is quoted as follows:

In all smaller tumors of the body of the uterus and the tubal cornea the formation of muscle fibers goes hand in hand with the adenomatous formation and is proportional, which is the more evident, the more distinct muscle fibers are formed around the tubular glands and the groups of glands. Where this condition is most fully developed and where the *moiré* strands appear most distinctly, there the glands are to be considered as the real cause of the myomatous formation. Just as during the embryoneal period the epithelium is first present, before the connective tissue and the enveloping muscular tissue, so also in its later growth does the gland become surrounded with a myomatous sheath only after it is itself completed. This sheath is therefore formed secondarily, and later on it may react upon the glandular structure and cause processes of growth in them.

Carl Abel does not think that the remnants of the Wolffian body alone is responsible for all tumors of this form. He thinks that such conditions must be present which will cause muscular tissue to become sensitive and likely to hypertrophy.

Von Recklinghausen says:

The adenomyoma occur most frequently in the body of the uterus on the dorsal wall, and in the tubal cornea on the cranial side. They grow either from isolated cell centers and form large masses, generally in the vascular and in the peripheral layers of the wall, or else they occur in numerous centers close to each other, or else quite scattered without any demarkation from the remaining substance and are not limited to any layer of the uterine wall.

They may make their way into the inner layers of the uterus and tube wall and form central tumors.

Abel states that the majority of examiners who have investigated the subject have come to the same conclusion as V. Recklinghausen. Further he states that the prognosis of this affection is much graver, than is the case with ordinary myomata and on account of the presence of the numerous epithelial formations there is also greater danger of carcinomatous degeneration.

Von Recklinghausen distinguishes the following forms in the uterus:

1. The hard form, with more muscle than adenomatous tissue.
2. The cystic form, with microscopic spaces and cysts.
3. The softer form with much adenomatous tissue, and islands of glands embedded in cytogenic tissue.
4. The softest form, with vascular and almost cystless adenomatous tissue, the so-called "angiomatous form."

The glands of these tumors are usually closely grouped. The myomatous portion of the tumor seems then to grow independently of the glandular, and the individual tubules of the glands have no muscle boundary. The characteristic element in these adenomyomata is furnished by the glands lined with simple cylindrical ciliated epithelium. In this respect they resemble the Wolffian body. In these tumors are also found (1) narrow tubules lined with high epithelium called "collecting tubules"; (2) wide twisting ducts with a lower pale cylindrical epithelium called "secreting tubules"; (3) wide blind ends lined with flat epithelium; (4) dilatations called "ampullæ." Von R. distinguishes structures which he states are incomplete glomeruli; differing from the malpighian bodies

in that they contain no vessel knots and in being covered with cylindrical epithelium.

Abel states that it has recently been claimed that the mucosa of the uterus and tube is the origin of these adenomyomata and he affirms from a study of the uterus and tube angles that in many instances such is the case. The displaced cells of the Wolffian body develop years after their transplantation and must not necessarily form the characteristic divisions of the original body tubules.

Von R. considers the following characteristics to be proof of origin from the mucosa. (1) A situation in any portion of the uterus other than the dorsal wall and the tubal angles. (2) A development from the central or inner layers of the myometrium. (3) A close apposition of the tumor to the mucosa in the greater portion of its extent. (4) Numerous communications with the mucosa. (5) A tendency to surround the uterine cavity in its entire circumference. (6) The absence of special characteristics in the structure of the glandular portions of the adenomyoma.

Taking up now some clinical reports we find W. P. Graves, of Boston, in March, 1906, reporting four cases of adenomyomata occurring in a total of 100 myomatous uteri covering a period of three and one-half years at the Free Hospital for Women, Boston. These cases represent the two distinct groups into which these tumors are classified with reference to their histogenesis. Graves describes his cases as follows:

CASE I.—Woman admitted suffering from dysmenorrhea. Examination disclosed the unusual condition of a sharp antelexion of the cervix combined with retroversion and short utero-sacral ligaments. Operation was performed and a hard mass about the size of a pigeon's egg was found lying on the posterior surface of the uterus on the level of the reflexion of the peritoneum from the uterus to the rectum. The mass was growing diffusely into the surrounding tissue. Patient made a good recovery. Microscopical examination showed the tumor to be made up of typical myomatous tissue in which were scattered gland inclusions which varied greatly in size. The epithelium lining the glands varied from a low cuboistal character to a high columnar variety on which cilia could be occasionally distinguished. The glands were of a dichotomous type. Surrounding most of the glands was a cytogenous tissue.

The essential features of this case were: First, occurrence in a uterus which presented developmental defects; second, occurrence on the posterior surface of the uterus, in an unusual position; third, diffuse char-

acter of the tumor; fourth, presence of branching gland structures lying in a bed of cytogenous tissue.

CASE II was a woman who entered the hospital with complaint of dysmenorrhea for 12 years. Diagnosis of fibroid was made. At the operation an intraligamentary parovarian cyst was found on the right side. On posterior wall of uterus were seen two hard subserous myomata which were found to be infiltrating the surrounding tissue and were dissected out.

Microscopical examination of the two small tumors showed the following: Typical myomatous tissue in which were scattered gland inclusions, both isolated and in groups, lined for the most part by columnar ciliated epithelium.

The entire group was embedded in a mass of cytogenous tissue.

The essential features of this case were: First, occurrence in connection with an intraligamentary cyst of developmental origin; second, characteristic position and diffuseness of the adenomyoma growing in connection with the fibroid enlargement of the base of the left tube; third, characteristic tubules described by V. Recklinghausen.

CASE III.—Woman with history of dysmenorrhea; diagnosis at entrance, multiple subserous fibroids.

Uterus was removed and on examination was found to be a septate uterus. At both tube angles were found diffuse myomatous growths in which could be seen on section small cysts.

Microscopic examination showed that these cysts were dilated gland inclusions having the same characteristic cylindrical, ciliated epithelium and embedded in cytogenous tissue in the manner described in the two previous cases. Some sections were cut so that the glands appeared as long slender tubules.

The essential features in this case were: First, occurring in a uterus showing other developmental defects; second, long slender isolated tubules.

The tumors here described correspond in nearly every particular to the adenomyomata described by V. Recklinghausen as deriving their origin from the Wolffian rests.

The only part of the evidence which is incomplete is that in no instance could any suggestion of glomeruli be discovered whatsoever. An additional and suggestive fact was that in all three cases there occurred, in connection with the adenomyomata, well marked developmental defects in some part of the pelvic organs.

Graves' next cases is the variety originating from the uterine mucosa. He remarks that Von R. has much less to say of this form, but recognizes it as a different species.

CASE IV.—A woman, 38 years old, single, admitted with a history of metrorrhagia. Entrance diagnosis was fibroid polyp of uterus. At operation uterus was found to be boggy and heavy, and was removed. The specimen on examination showed a large soft uterus, from which extended a rather soft polypoid tumor from the amputated cervix. Section of the uterus into the canal showed that the tumor was growing from the circumference of the canal, though mostly from the posterior wall. On the surface of the tumor, especially at the periphery, were small cystic openings. Microscopic examination showed the tumor to be made up of smooth muscular tissue and proliferating gland tissue. Glands were lined with low cuboidal epithelium and contained mucous secretions. There was little cytogenous tissue, the muscular tissue for the most part growing closely in contact with the basement membrane. Further examination of the tumor near its base showed the myomatous tissue to be much less in evidence, while glandular tissue was proliferating in great profusion and the non-glandular substance became more and more cytogenous* in character.

The sections of the myometrium near the point of origin of the growth showed that the glands had actually invaded the wall of the uterus to at least half its width and were adenocarcinomatous in character. The tubes were both dilated at the junction with the uterine horns and masses of soft friable material were found within them.

Microscopic examination, however, showed that these masses were not growing from the lining membrane of the tubes which, though much dilated, preserved their integrity; but that they were in-growths of the proliferating neoplasm which were simply pushing their way into the openings of the tubes, taking the line of least resistance. The glandular structures found in this tumor evidently connected with the endometrial glands of the uterus, and corresponded with them in general make up.

The point of origin of this tumor, the appearance of the glands, the carcinomatous invasion from within outward and its general characteristics corresponding with the description of Von Recklinghausen form convincing proof that it derived its histogenesis from the endometrium.

An article by S. J. M. Cameron and A. Leitch in *Lancet*, 1904, reviews the subject of adenomyomata and cites several cases brought to their attention.

They say: These new growths have all the macroscopic appearance of a fibromyoma. There are, perhaps, only two points which may lead to a diagnosis, the absence of a definite capsule, and the absence of whorls so characteristic of fibromyoma.

They go on and recite their variety and usual situation as is noted by writers quoted above. Also their clinical deductions correspond with

* Cytogenous tissue is a loose reticular tissue made up of round and spindle-shaped cells, which do not lie in close contiguity. It is found normally surrounding gland elements, as, for example, in the uterine and intestinal mucosa.

those of Von Recklinghausen and Graves, such as hemorrhage and connection with adenocarcinoma.

Hysterectomy is considered the only treatment.

Cameron and Leitch review four cases of this form of new growth. The complaint in each case was of bleeding and dysmenorrhea. Diagnosis of fibromyoma was made in cases where a diagnosis was possible. The uterus was enlarged in each case and was sensitive to pressure. On section no capsule was made out. They recite the various theories advanced as to the origin of this variety of neoplasm. All of which have been referred to.

They continue: The association of adenocarcinoma with adenomyomata may be more than accidental. An instance is cited from pathological reports wherein the adenomyomatous tissue shows a typical adenocarcinoma with round cell infiltration and invading carcinoma cells.

They sum up their views of the neoplasm as follows: First, an ingrowth of the structures of the endometrium into the muscular wall as is seen in hypertrophic endometritis—"the stage of glandular inclusion"; second, a hyperplasia of the inclusions and a progressive infiltration stimulating a hyperplasia of the muscle—"the stage of adenomyoma benignum"; third, a loss of relations between glandular and muscular elements, the growth of the former outstripping that of the latter, inversion and eversion of the epithelium with a consequent displacement of the interglandular stroma and an encroachment on the muscle, the irritation of the growth causing a round cell infiltration—the stage of "malignant adenoma"; and fourth, the loss of relations between one epithelial cell and another, the riotous proliferation and heaping up of immature epithelial cells breaking through the restraining basement membrane invading and destroying the adjacent muscle—the stage of adenocarcinoma."

We will now review in brief a case of our own at the City Hospital which has much in common with what we have recited.

CASE 751, gynecological, K. F., age 46, married, housewife, American, admitted July 5, 1906. Discharged July 26. Days in hospital, 21. Diagnosis fibroid of uterus degenerating. Result good. Operation, vaginal hysterectomy. Family history was negative.

Past History.—Menstrual periods were regular and normal until about a year ago when some pain was noticed and flow was prolonged and profuse. At her last period, which recently ended, the flow was profuse and lasted two weeks. On entering she complained of a dragging pain in pelvis which was exaggerated on standing.

Two sections were made from the uterus. One from a nodule on posterior surface of fundus, other from the uterine cavity. Microscopical examination of the nodule showed groups of glands surrounded by much fibrous connective tissue. Muscular tissue was scanty.

The glands were lined with columnar epithelium. When cut lengthwise glands had the appearance of tubules.

The section from the uterine cavity showed similar groups of glands with columnar epithelium which had the appearance of being ciliated. Although fibrous tissue predominated the remains of the muscular tissue were more evident.

It will be noted that the clinical history of this case corresponds with those recited by Graves and by Cameron and Leith. Also the location of the neoplasm on posterior wall of fundus is in accord. The pathological section show changes also in harmony.

The growth in the cavity of the uterus was undoubtedly an extension of the process on the posterior wall as, Von Recklinghausen states that these growths may make their way into the inner layers of the uterus and tube wall.

It is noteworthy that our specimen contained much fibrous connective tissue, particularly was this so in the section taken from the nodule on the posterior wall.

THE CLIMATE OF NEW MEXICO, NATURE'S SANATORIUM FOR CONSUMPTIVES.*

By PAUL M. CARRINGTON, M. D., FORT STANTON, NEW MEXICO,

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of the United States.*

INTRODUCTORY.

So much has already been written and the climatic conditions in New Mexico are already so well known to you that I feel it necessary to explain why I am addressing you on this subject.

Many inquiries are received from physicians and others concerning the climatic and other conditions in New Mexico, and the literature on the

* Reprinted from the New York Medical Journal for July 6, 1907.

subject is so voluminous, and there being so far as I know no single publication of moderate dimensions covering all the points upon which information is asked, I thought it might not be amiss to collect and publish in a convenient and condensed form authentic and unprejudiced observations on the subject covered by this paper to meet the demands for information referred to.

New Mexico alone is treated of in this article, partly for the reason that it is the only portion of the "arid southwest" with which I am personally acquainted, and because the conditions prevailing in New Mexico are in a large measure typical of the entire region; I speak not only from a study of the official records and reports, but also after a residence at Fort Stanton, in central New Mexico, of about six and one-half years.

GEOGRAPHY.

Geographically New Mexico lies south of Colorado, east of Arizona, west of Texas, and north of Texas and Mexico. It extends from the 37° of north latitude to the 32° of north latitude, with its southwestern corner going as far south as about 31.3° . The 103d meridian west of Greenwich forms its eastern border, and the 109th its western border. New Mexico is a portion of that region known as the "arid southwest," which is composed of Colorado, western Texas, New Mexico, Arizona, and southern California; the climatic conditions prevailing in this entire section possess the same general characteristics, although in various degrees as modified, by latitude, altitude, and topography.

TOPOGRAPHY.

Generally speaking New Mexico is mountainous with here and there elevated table lands. The mountains are portions of the Rocky Mountain range, and extend in a general northerly and southerly direction from its most northern to its extreme southern boundary. The mountains and foot hills extend to its most eastern border on the north, and its plains and low altitudes are found in the southeastern corner, but even here the altitude exceeds 3000 feet above sea level. The mountains of greatest altitude are found in northwest and south central New Mexico; the Truchas peaks in Santa Fé county are the highest in the

Territory, rising to an altitude of 13,275, 13,140, and 13,060 feet, respectively. Here and there in various portions of the Territory are to be found numerous mountain valleys varying in width from a few hundred yards to several miles, and surrounded on all sides by high mountains, and in many instances traversed by beautiful streams of cold, clear, pure water, which have their origin in the surrounding mountains. The tendency of these streams to sink into the ground upon reaching the plateaus and the scarcity of fuel in those regions where the roots of the mesquite bush are used as fuel have lead to the localism, which originally applied to the staked plains of western Texas, also applies to a portion of New Mexico: "The land where one must climb for water, dig for wood, and spell hickory with a J." This last clause, of course, referring to the pronunciation by the Spanish of the letter J. The mountainous and hilly character of the topography of New Mexico has a most important bearing on its climatic conditions. No portion of the Territory of New Mexico has, so far as I have been able to ascertain, an altitude of less than 3000 feet, and the greater portion of it is more than 5000 feet. The altitude also modifies very materially its climatic conditions, especially with regard to temperature.

CLIMATE.

a. Climate has been defined to be the condition of a place in relation to the various phenomena, as temperature, moisture, etc., especially as they affect animal and vegetable life.

b. The sum of atmospheric conditions as recorded for a long period of time; or in other words, it is the totality of weather, while weather is the physical condition of the atmosphere at a given time or during a limited period.

"The climate of a place is ascertained by a study of its continuous weather records for a long period of years; the atmospheric pressure, the temperature, the rainfall, the snowfall, the time and frequency of frost, the extremes of heat and cold, the direction and velocity of the wind, the amount of air that flows from different points of the compass, the amount and intensity of sunshine, the humidity and transparency of the atmosphere, and its electrification." (Professor Willis L. Moore.)

Professor Moore also says: "Climate affects the health, happiness, and well being of people more than any other condition that goes to make up their environment. Within the broad confines of the United States there are

many, but not all, shades and varieties of climate. One of the questions most frequently asked is: Where shall I find a climate possessing both dryness and equability of temperature? To this interrogatory reply must be made that the ideal climate as regards equability of temperature and absence of moisture does not exist in the United States, but that the nearest approach to it will be found in the great southwest. . . . The temperature of the southwest is not equable in the sense of having an extremely small *daily* range, but it possesses the quality of annual uniformity in a greater degree than will generally be found elsewhere except on the seacoast, and there the humidity is great."

This testimony from such an eminent authority should be convincing as to the climate of the great southwest, as the conclusions of Professor Moore must, by reason of his official position, have been based upon a long period of scientific observations.

The climatic conditions prevailing in New Mexico are practically the same in general features as are to be found in the entire region included under the term "arid southwest," the difference being in degree rather than kind. In general terms, it may be said that the climate of this region is characterized by a large percentage of possible sunshine, a low degree of relative humidity with low temperatures at night, and a low percentage of soil moisture; these conditions being modified to a greater or less extent by the topography of the particular locality under consideration, as well as by its altitude and latitude. Much more than half the yearly rain falls in July and August—usually in the afternoon—when it is most needed by growing vegetation and for cooling the atmosphere. Average temperatures for the arid southwest in general, even for the Territory of New Mexico, would be valueless, because of the wide difference between north and south New Mexico. There is a difference of more than five degrees latitude, which alone would have considerable influence on the temperature of the northern portion, as compared with the southern. Then there is the effect of altitude, as well as the topography, to be taken into consideration. There is usually in all this region a very considerable daily range of temperature, running as much at times as 50° or 60° F., and averaging about 30° to 40° F. The low temperatures, of course, occur at night, and, therefore, do not detract from the attractiveness of the climate as a whole even in winter, while in summer the low night temperatures make it possible to sleep in comfort, and in most localities the use

of blankets at night is necessary for comfort even in summer. Even during the hottest days in summer when the thermometer frequently registers from 80° to 90° F., and in some localities even more, the heat is never oppressive on account of the low relative humidity, and sunstroke, so common in the cities of the east, is practically unknown in the arid southwest, and while a man may perspire pretty freely if actively exercising in the sun, he is quickly relieved upon seeking the shade where the perspiration evaporates almost instantly. On the other hand, the coldest days in winter are comfortable if the sun is shining, and it usually is. Overcoats are rarely worn on sunshiny days, and it is a common occurrence at the Fort Stanton Sanatorium to see patients during midwinter lounging or playing croquet in their shirt sleeves, with the thermometer showing a temperature of from 30° to 50° F.

That feature of the climate of New Mexico which detracts more than any other from its general excellence is the occurrence of high winds in the late winter or early spring months. These winds prevail with variable frequency during the season mentioned throughout the Territory, being more severe in the less mountainous regions. They are also referred to as "sand or dust storms." Their direction is usually from the west, southwest, or northwest, and they frequently prevail from two to three days at a time. After the wind has been blowing from twelve to twenty-four hours a greater or less quantity of fine dust becomes apparent and is extremely annoying. The amount of dust is governed not only by the topography of the locality—the wind and dust both being less severe in localities protected by high mountains than on the plateaus—but also by the amount of rain and snow fall in the preceding months. During the past four years the rain and snow fall have been above the normal, and during these years wind storms have been very rare, with scarcely any dust at all. During the years from 1901 to 1903, inclusive, when the entire precipitation was less than ten inches at Fort Stanton, and generally low throughout the Territory, "three day" wind storms prevailed at frequent intervals throughout February, March, and April. The velocity of the wind during these storms is from thirty to fifty miles. The wind usually blows steadily, reaching its maximum intensity within a few hours, and continues with the exception of a lull about sunset for the usual full period of three days. Such storms have an undoubted

effect on the nervous system of patients, most of whom become irritable and cross on the second day and almost unbearable on the third. When the storm subsides the fact is clearly recorded on the smiling and cheerful faces of everyone.

The second objectionable feature of the New Mexico climate is a wind which occasionally occurs during the winter and spring months. It blows from the east or southeast, and, like the wind just described, usually lasts two or three days. After the first fifteen to twenty hours clouds appear, and if the wind continues there is usually fog, rain, or snow, according to the season. It is extremely rare that these storms continue for more than three days at a time, but in a residence of more than six years in New Mexico I have seen one period of east wind with alternating fog, rain, and snow, which prevailed for sixteen days, with two intervals of one day each during which the sun shone beautifully.

Beyond these two winds the climate of New Mexico is very nearly perfect; we do have, it is true, very low temperatures at times, and in some localities, as the Pecos Valley, where the north wind has a long sweep, occasional blizzards occur, but the low temperatures almost always occur at night when every one is comfortably tucked in with plenty of blankets, and during such times the sunshiny days and dry atmosphere make life a delight.

These few objectionable features have been mentioned together with the excellencies of the climate in an effort to be perfectly fair, and avoid disappointing those who come to New Mexico expecting to find it literally a land of perpetual sunshine and balmy breezes.

To put it otherwise, while the climate is always superb we occasionally have bad weather; and no amount of description, no multitude of statistical tables, can give an adequate idea of the delightful, invigorating climate of New Mexico, which must be experienced to be fully appreciated. The warm, sunny days of winter, no less than the cool, shady days of summer, invite the invalid and the robust to the outdoor life.

I have perhaps conveyed an erroneous impression regarding the frequency of the the so-called three day winds; as a matter of fact, the typical storm described is rather rare; more frequently the wind ceases after blowing twelve to forty-eight hours.

SOIL MOISTURE AND EVAPORATION.

The effect of soil moisture upon the health of a locality is well recognized, and a low percentage always makes for salubrity of climate. Even the heavy summer rains only penetrate the ground twelve or fifteen inches at most, and this moisture is quickly returned to the atmosphere by evaporation.

The annual evaporation of water at Albuquerque—a tank two feet square by one foot deep, made of wood and lined with heavy zinc sheeting having been used—showed the evaporation to be something more than eighty inches, as against about forty inches at Boston.

These tests were also conducted at the Hadley Laboratory, the purpose being to determine in a practical way the dryness of the New Mexico climate.

(TO BE CONTINUED.)

READING, PA., August 7, 1907.

DR. CHARLES E. BRACK, BALTIMORE, MD.

Dear Doctor.—The ALUMNI JOURNAL just received. Find so much of interest in it today that reminds me of the P. & S. and the many happy days spent there, and the class of '86 especially, of which I was a member, and the faculty now nearly all gone to the great beyond.

My preceptor, Dr. W. Z. Bowman, was a member of class of '80, I think, ran a large practice, abundantly successful, probably the largest practice in this city of 100,000 people. Died on March 17, 1906, of pyæmic abscess of neck and head. I am now the only P. & S. man in general practice in this city or neighborhood.

Doing well, collecting a good income yearly. Am married; have one boy 14.

Think of 21 years of practice, Doctor. I am really getting into the ranks of the older men. But I don't feel so!

Remember me to the boys, and especially the '86 men. Shall be pleased to hear from any of them.

Enclosed find \$1.00, covering year's subscription.

Respectfully,

J. C. KNAUER, M. D.

P. S. Say hello! to Harry Friedenwald for me. He was a class mate.

J. C. K.

WILLIAM S. GARDNER, M. D., EDITOR,
6 W. Preston Street.

JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., BUSINESS MANAGER,
500 E. Twentieth St.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE NEW MEDICAL LIBRARY.

For some years past the splendid collection of medical books and journals in the Library of the Medical and Chirurgical Faculty of Maryland has been open to the medical students of the various medical schools. It has been made use of by many students and should be by many more. Those who remember the old building on Eutaw Street will be pleased to learn that there is a movement on foot to get a new fireproof building in which to store the valuable collection of books, as well as a meeting place for the various medical societies.

The money for the new building is being raised by subscription and already a very good start has been made, and it is to be hoped that a new building may be started before very long. To those who have used the library and feel indebted to it we urge that a subscription be sent towards the new building. To those who are interested in the cause of medical education we suggest that there is no place where a contribution will be of such service as in the cause of medical libraries. If you have a boy whom you are going to send to Baltimore for his medical education lend a helping hand to the new building and let the son reap the benefits.

All inquiries and contributions may be sent to Dr. John Ruhräh, 847 North Eutaw Street, Baltimore, and all checks may be made payable to the Building Fund of the Medical and Chirurgical Faculty.

Obituary.

DR. JAMES DUDLEY MOSHER, '86, died at his home in Rawdon, N. S., May 4.

DR. B. L. REX, '90, died suddenly at his home in Hillsboro, Va., from heart disease, September 26, aged 55.

DR. THOMAS B. RIDDICK, '93, died at his home in Woodville, N. C., March 4, from nephritis, after an illness of six months, aged 49.

DR. WILLIAM JACKSON KENDALL, '84, died at his home in Paris, Va., February 20, from pneumonia, after an illness of five days, aged 45.

DR. FLEET JOHN COOPER, '84, a member of the Medical Society of the State of North Carolina and Sampson County Medical Society, died at his home in Roseboro, N. C., July 11, after an illness of several weeks, aged 47.

DR. WILLIAM RODES, '76, of Lexington, Ky., who had suffered from rheumatism for the last four years and had spent his winters in Clear Water Harbor, Fla., died suddenly at that place, May 14, from rheumatic endocarditis, aged 56.

DR. ANDREW G. GUILER, physician and surgeon, and well known throughout the Monongahela Valley, died September 25, at his home in Belleverson, of typhoid pneumonia.

Dr. Guiler was born January 29, 1859. He was graduated from the College in March, 1879, and after taking a special course in gynecology located at Belleverson, where he had since been successfully engaged in the practice of his profession.

Marriages.

DR. ARTHUR CLARE PALMATEER was married to MISS LETHA BERNICE WHITCOMB, at Walton, N. Y., on Wednesday, September 18.

DR. EARLE S. MUSGRAVE was married August 7, to ELIZA FLOURNEY WOOD, at Standard, West Virginia, where they will make their home.

Correspondence.

MILFORD, UTAH, June 30, 1907.

DR. CHARLES E. BRACK, Baltimore, Md.

I have received a copy of the ALUMNI JOURNAL which brings to my mind the pleasant days while in college, and it makes me very anxious to visit the old college again. I was very much grieved to learn of Dr. Latimer's death. I have often thought of him, and the good advice given us in his branch. It did me a great deal of good then, and more since I have been practicing. How nice to know one has done some good in the world, as every professor in the P. and S. will have the satisfaction of leaving behind a record for the progression of humanity.

Enclosed find one dollar for the ALUMNI JOURNAL.

F. J. BURTON, '04.

EAST ORANGE, N. J., June 19, 1907.

DR. BRACK.

Dear Doctor.—Yours received on the 11th, containing Hazelton's address, and I must thank you very much for your trouble.

As for the class reunion, I would certainly try to get them all together next spring, and I think they would have a very good time, and enjoy seeing old friends once again. I am going to sound them on the matter, and would like very much if you would help me out in the matter by making them acquainted with the fact through the next issue of the JOURNAL.

Thanking you again for your trouble, I remain,

Yours fraternally,

F. W. LOCKWOOD.

TARENTUM, PA., June 17, 1907.

DR. CHAS. E. BRACK.

Dear Sir.—Enclosed find check for \$1.00 for the JOURNAL, hoping you will overlook my indifference in the past.

I was pleased to see a list of my class in the January number and surprised and pleased to know that there are 50 survivors of the '79 members of the class of 1879.

I am just now stirred up by a recent letter from Dr. Cole, of Roanoke, Va., suggesting a reunion of our class next commencement time. I am strongly in favor of it, and think if we are ever to have one it should be soon, before we get any older or fewer. Perhaps we could have it this summer.

I shall do my share to get up an interest among the boys, now that I have the the addresses. It seems strange I have never heard from any of those 50 in all these years, until this from Dr. Cole.

If you care to publish this you may add that I am at present in very good health, apparently sound, have prospered, have a family, mostly grown up, and am just as young in spirit, if not more so, than I was when we parted in '79. I was then only 20 years and 10 months old, and am now but 49. I was the tall, thin, "dignified" fellow that generally kept very quiet. Won't the dear old comrades favor me with a letter? Let all take a hand to boost the reunion!

Fraternally yours,

ALVA L. CHAPMAN, '79.

ATHENS, N. Y., July 27, 1907.

COLLEGE OF PHYSICIANS AND SURGEONS.

Gentlemen.—I received this day a catalogue of your excellent institution marked Dr. F. T. Lape. I should have notified you sooner, but in our grief it was neglected. My son, one of your graduates, died of tuberculosis September 4, 1905. He had built a fine practice in Poughkeepsie, N. Y., where he remained until obliged by the dread disease to give it up, after a long, hard fight. The result was as usual. He held your college in great esteem.

Most respectfully yours,

F. R. LAPE.

FORT PIKIT, MINDANAO, May 20, 1907.

My Dear Doctor.—Your letter and the January JOURNAL were received a few days ago and I was glad to have both. The last time I saw Dr. Pond was in Cebue, Cebue, P. I., and at that time he was Health Officer for that district, his position being under the civil government. He is also surgeon for the railroad which is being built on Cebue. I

saw Owen about a month ago as I was going to Zamboanga. He had been to Jolo with a company, but was on his way back to the Division Hospital in Manila. He expects to return home shortly, and I saw in the last Manila paper where he had been granted three months leave with permission to visit Japan and China. He told me that he wanted to return by the eastern route. From what I can hear Pond is doing very well.

I suppose you are in for exams. about this time and are very busy. I would like very much to be there this year, but as that is impossible I must content myself with a mind's picture of the commencement. Drowne is the only member of my class that I hear from, and I have not had a letter from him for several months.

My present station is about seventy-five up the Cotabato River, and there is just one company of Philippine scouts here, so I have very little to do. I am mailing you the pictures I spoke of in my last letter. Sorry that I can not give you a good history of the cases, but they are all Moroes and they do not understand English or Spanish, and I do not know their language, so I am not able to get a word out of them. I have found one case of the new filaria, described by Craig and Ashburn, of the Board For the Study of Tropical Diseases. This case of *Filaria Philippinensis* was sent to them for observation. I am now making a systematic examination of the feces of all patients admitted to the hospital to determine the frequency of the occurrence of the *Trichocephalus*, *Ascaris Lumbricoides*, and *Ankylostoma*, in natives not suffering from bowel complaint. Let me hear from you and give my best regards to all. Address me at Manila, care of Chief Surgeon. With best wishes, I am,

Fraternally yours,

CHARLES H. HALLIDAY.

FORT PIKIT, MIND., P. I., May 31, 1907.

Dear Doctor.—I inclose a short piece on the treatment of Dhobie itch, which if you deem worthy I will be glad to have it published in the ALUMNI JOURNAL. I fully realize that it is wanting in many respects, but have hoped that it may be of some use. I am doing some work now on intestinal parasites, which if I can get in some kind of shape will

send you before the year is out. Have you heard anything of J. Plumer Cole. I had a letter from him while I was in Alaska, and at that time he was with the Standard Oil people. At the time of his letter he was in Seattle, but did not expect to remain there for any length of time. He has a brother connected with the Standard Oil Co., and I believe he is in Philadelphia. I had a letter from Drowne yesterday, and he said he was going to give up the practice of medicine. With best regards to all,

Fraternally yours,

CHARLES H. HALLIDAY.

PEORIA, July 24, 1907.

Dear Doctor Brack.—On returning from my vacation I find on my table a number of the JOURNAL OF THE ALUMNI ASSOCIATION of the College of Physicians and Surgeons of Baltimore. I also received the number before this giving an account of the untimely death of my talented and loved room-mate, Dr. H. W. Hitzrot, of McKeesport, Pa. I thought I had sent in my subscription then, but as I failed to do so, I will now. I can't help noticing what a quarter of a century has done for the faculty of our old Alma Mater. In looking over the list of professors who signed my diploma in March, 1880, I only see two names, those of Drs. Bevan and Simon, as regular professors. I am glad to see that of Dr. Thomas Opie still heading the list, if he is only Emeritus. I hope he still possesses the same delicate touch in those long, slender gynæcological fingers of his. I notice with interest the notice of the death of Dr. Latimer, hardly ripe in years, but fully matured in good works, who in my day was one of the most popular members of the faculty, as evidence of his popularity with the students, I will give a little circumstance that happened just after the holidays in 1880. As the writer in the JOURNAL has said, he was as gentle and kind as a woman and almost effeminate in his manner, still, he liked a good joke and also liked to play one on the boys (the girls were not studying medicine then). One morning, before beginning his lecture, he made the announcement that he wished to make a correction. We could tell from the expression on his face that there was some fun coming. "One of the professors of the University of Pennsylvania used to say that he would not sign a young man's

diploma who had not paid tribute to Mars." "Now," said Dr. Latimer, "I would like to state to the class of 1880 that this faculty makes no such requirement." It was interesting to note the number of red faces in the audience. You can say to any of the class of 1880 that I have been prosperous and would be glad to hear from any of the old class that may still be in existence. I am

Very truly yours,
J. F. COOPER, M. D.

THREE MILE BAY, N. Y., August 12, 1907.

DR. CHAS. E. BRACK, BALTIMORE, MD.

Dear Doctor.—Enclosed find my check for (2.00) two dollars. Please send by mail to Wm. Graves, Point Peninsula, N. Y., one dollar's worth of the July issue of ALUMNI ASSOCIATION JOURNAL, containing the obituary of Dr. Wm. B. Graves, and please give me credit for the other dollar on my subscription for the JOURNAL.

I had expected to be with you at your last Alumni Meeting, and now hope to meet with you next year.

I have never visited Baltimore since my graduation in 1882, and am so far north I seldom see any of the old boys.

I came directly to this place upon graduation, and have practiced here continuously since. The class of 1882 was a large one, but I see very few of their names in the JOURNAL.

With best wishes for everything connected with the C. P. & S., I am

Very truly,
W. A. VINCENT.

BALTIMORE, October, 1907.

Dear Sir.—At the recent Annual Meeting of the American Pharmaceutical Association the undersigned was directed to send you a copy of the following resolutions:

WHEREAS, The American Medical Association, the American Pharmaceutical Association and the National Association of Retail Druggists together with many State and local organizations and journals in both professions have been for some years endeavoring to bring about a return to the practice of medicine based on the Pharmacopœia, and

WHEREAS, The medical colleges are represented on the Committee of Revision of the U. S. Pharmacopœia, and

WHEREAS, It is manifest to the thoughtful men both in medicine and pharmacy that a very large number of medical men might be better informed

regarding the Pharmacopœia as a book of reference and standards. Be it therefore

Resolved, That it is the sense of the American Pharmaceutical Association in convention assembled, that a great advance in the ethical practice of medicine and pharmacy will be made when the medical colleges make the Pharmacopœia a prescribed text-book or book of reference and require a familiarity with it in their examinations.

Resolved, That we request the governing authorities of all medical colleges in the United States to put into force such a ruling in their respective institutions as will insure in future classes a well grounded knowledge of materia medica and Pharmacognosy, as set forth in the Pharmacopœia.

Resolved, That the General Secretary be directed to transmit a copy of these resolutions to each medical college in the United States and to the medical and pharmaceutical press.

Yours very truly,

CHAS. CASPARI, JR.,

General Secretary.

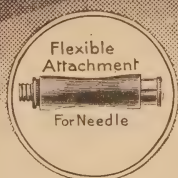
HOME-MADE BUTTERMILK.

It is now within the power of every household to have an abundance of that refreshing and healthful summer (also winter) drink—buttermilk. To the present time no one knows of any source of buttermilk except from the butter-maker; but now-a-days the butter-maker does his work so well that the buttermilk is entirely deprived of the delicious little grains of fat which add so much to its food qualities as well as to taste. True buttermilk, made direct from fresh rich milk, within a few hours, of the finest flavor and taste, nutritious and more excellent than the article as originally known, can now be prepared in any kitchen. This is done by taking a quart of fresh, rich milk, adding a pinch of salt and about a half-pint of hot water to raise the temperature to body heat, and lastly adding a tablet which contains a pure culture of lactic acid bacteria. Place all in a pitcher, cover with a napkin, and let stand for twenty to twenty-four hours at the ordinary temperature, and there is your perfect buttermilk. The tablets are made by Parke, Davis & Co., the pharmaceutical and chemical manufacturers of Detroit, Michigan, and are called "Lactone," or buttermilk tablets.

On the farm, in the process of butter-making, the cream is allowed to sour spontaneously and is then churned. The souring is the lactic acid fermentation caused by lactic acid bacteria or ferments. The difference between the new and old process is one of method and not result. In the old, the lactic fermentation is waited for and expected to occur spontaneously, with disappointment sometimes. In the new, the ferment in pure culture is directly planted in the milk, and the desired fermentation is secured without fail. In Bible days, spontaneous fermentation of dough was dependent upon to leaven or lighten bread, and failure frequently attended the process, the dough putrefying instead of fermenting, and was then lost. Finally, man learned to add yeast to the dough and not to depend upon spontaneous processes, with the result of always securing the right fermentation and making a better and more nutritious bread. This new buttermilk process is a like improvement.—*Monthly Bulletin Indiana State Board of Health*, June, 1907.

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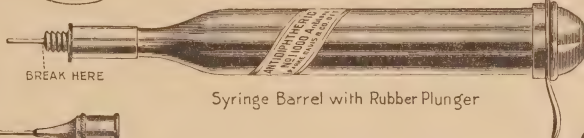
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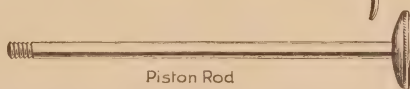
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The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

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Vol. X

No. 4

JANUARY, 1908

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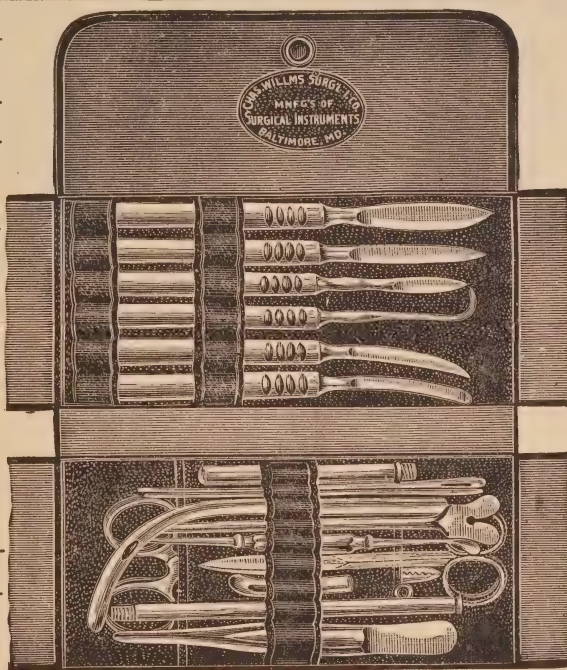
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THE JOURNAL
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THE IMMEDIATE REPAIR OF THE CERVIX.

BY DR. CHAS. EMIL BRACK, '95.

The recognition of the importance of cervical lacerations is of comparatively recent date.

In 1851 Sir James Y. Simpson recognized that it was common in first labors. The full recognition of cervical lacerations and the realization of their consequences were pointed out by T. A. Emmett in 1862, to whom we are also indebted for its remedy.

The older writers commonly supposed that lacerations were only ulcerations.

As late as 1889 Lawson Tait held that metritis was the cause of subinvolution and that nothing more useless than the Emmett operation had ever been invented. Trachelorrhaphy has been adopted as a perfectly proper and efficient gynaecological operation. Unfortunately some of the consequences of cervical lacerations such as cervicitis, endocervicitis, endometritis, metritis and especially subinvolution, and a train of nervous phenomena are sometimes so well established before repair work is undertaken that a more recent operation is being advocated.

The tendency to future malignancy must not be overlooked in this connection. Whether the operation should be done to best advantage immediately after labor at some time during the puerperium or later at a time not too remote is open for discussion.

It is the purpose of this paper to present in a modest way the limited experience in a number of cases in which the immediate repair has been

followed by unusually good results. In a few cases the repair after recent labor of older lacerations has given results far superior than those obtained by trachelorrhaphy as a separate operation after partial repair had taken place.

It will be of interest to review the opinion of some of the writers on this subject.

Physiologically there is laceration of the cervix in all primipara and in some multipara. Laceration is usually bilateral so that in women who have borne children the external os is no longer a small round opening surrounded by a perfect ring of tissue but a more or less funnel-shaped aperture placed transversely between two well marked lips. It is only when the tears extend into the vaginal vault that they become pathological.

The causes are described as obstetrical operations with insufficiently dilated cervix. Change in the tissues of the cervix, precipitate labor, short second stage with violent contraction. Over-size of head and child, too early rupture of membranes, accouchement forces, etc. Symptoms are usually not present sufficient to indicate the amount of damage. They are chiefly pain and hemorrhage with contracted uterus. The condition when not repaired may lead to sepsis and later to chronic uterine disease and displacement. Treatment should consist of hot water injections, direct compression. It is preferable in most cases to unite the parts.¹

According to Hirst, hemorrhage from a torn cervix directly after labor may be controlled in two ways. By ligatures, which are certain to affect the desired result, but which are difficult to insert and increase the danger of septic infection. Stitches placed in the relaxed cervix will probably not be tight enough at the end of twenty-four hours. *Hirst* has since modified his views and while he does not favor immediate repair is a strong advocate of repair during the puerperium. *Jewett* contends that even in cases of severe laceration it has generally been thought better to remedy any defect later rather than add to the severe trials of the woman at that time. He says, however, that "the most recent literature shows an increasing tendency to undertake the immediate operation in less severe cases also. The obvious advantage is the closing of avenues by which infective material may enter. We also avoid injurious results,

¹ American Text-book of Obstetrics.

which may occur if repair is not permitted later." *Williams* advocates immediate repair when deep lacerations are accompanied by hemorrhage. On the other hand he deems it advisable to leave the patient alone rather than subject her to manipulations necessary to the repair, which inevitably exposes her to risks of infection. He says, "moreover, in the majority of cases such tears heal spontaneously and in the exceptional cases better results are obtained by secondary operation later in the puerperium.

Hemorrhage is often controlled by compression of the tissues by the head and by thrombosis of the vessels, so that an extensive tear may give rise to no symptoms at the time of delivery."

Craig,² after a discussion of the subject, forms the following conclusions:

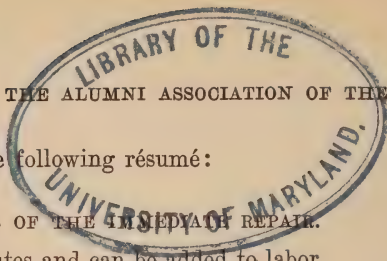
1. Immediate repair is indicated in exceptional cases only aside from the control of hemorrhage.
2. Mediate repair is contra-indicated except in unusual cases.
3. Secondary repair is indicated as soon as symptoms are definitely due to lacerations, such symptoms failing of relief by palliative measures or recurring after apparent palliative cure. Operation should be prompt but not necessarily early.

*Dickinson's*³ operations for the repair of the cervix either immediately after labor or years after are far from the best, for just after delivery the cervix is swollen and distorted and accuracy in adaptation impossible because we are unable to identify the parts with exactness. On the other hand months or years after delivery the torn cervix is deformed and altered by contraction, erosion and chronic inflammation. By preference from the 3d-14th day of the puerperium should be selected, when the swelling has subsided and the parts are fairly normal in shape and size. Summing up he advises:

- (a) Suture at close of labor in cases of post partum hemorrhage.
- (b) Sew all cervical tears in first week in conjunction with perineal operation, when the latter is of such character as to make a few days delay desirable.
- (c) Restore severe injuries in from three to ten days.

² Journal American Medical Association, October 31, 1903.

³ New York and Philadelphia Medical Journal, March 26, 1904.



A. H. Gardner* gives the following résumé:

ADVANTAGES OF THE PRIMARY REPAIR.

1. Requires but few minutes and can be added to labor.
2. A few whiffs of chloroform additional is all that is necessary.
3. Does not make secondary operation necessary; gives less inconvenience to patient and surgeon.
4. Can be done at home.
5. Prevents sepsis.
6. Removes the more frequent cause of subinvolution.
7. No particular device or instrument necessary.
8. Almost as good result as suturing perineum, pelvic floor, etc.
9. Has usually proved successful.

DISADVANTAGES.

1. Cervix swollen, distorted, stretched and work difficult.
2. In twenty-five per cent no repair is necessary.
3. Bleeding obscures field.
4. Punctured points bleed as freely as torn surfaces.
5. Sepsis may be carried by fingers, sutures and instruments.
6. Traction upon uterine supports may produce prolapse.
7. Manipulation may produce embolism.
8. When shrinkage takes place wound surfaces are exposed to infection as before suture.
9. Sutures in the swollen cervix hang like rings after contraction and involution, and then do no good.
10. May interfere with drainage.
11. We must have assistance.
12. Deliberation and care are impossible at this time.

INTERMEDIATE REPAIR ADVANTAGES.

1. Less danger of infection. Hirst thinks that there is less danger of infection five days after delivery.
3. Woman is in better condition.
4. Can arrange time and assistance.

*New York Medical Record, August 26, 1905.

DISADVANTAGES.

1. Secondary operation breaks into convalescence most unpleasantly, and anæsthetic is given when milk secretion is well established and baby nursing well.

2. Operation at this time very probably refused.

ADVANTAGES OF WAITING.

1. Twenty-five per cent heal spontaneously.
2. Some never have symptoms.
3. Treatment sometimes relieves symptoms.
4. Easy to choose time, place and assistance.

DISADVANTAGES.

1. Many women suffer and bear pain and discomfort for years before consulting a physician.

2. Long train of nervous and hysterical symptoms existing for a long time do not always disappear when primary cause is finally removed.

Donahue,^o in his house service found only two women out of 75, who had no laceration of cervix. The other 73 became gynecological patients. 18 were operated about six weeks later. In every case involution was more rapid. An immediate trachelorrhaphy upon a patient who had in previous puerperiums suffered from subinvolution and its wonderful results convinced him of its value. In all cases immediate trachelorrhaphy has proven eminently successful in his hands.

Norris states that in many cases while the wound is healing the uterus undergoes a chronic interstitial change and a train of symptoms evolved which often persists, but would not exist if the cervix had been repaired at an earlier date.

Coles recommends the immediate repair of all lacerations of one-half inch or more. He cites 2200 cases in Jefferson Maternity, Philadelphia. In 181 immediate trachelorrhaphy was performed. Rise of temperature in eight cases. None of stitches infected. Union good in 159 cases. Fair in 20. Failure in two.

Bartholow^o states that a wound of cervical tissue unless almost imme-

^o New York and Philadelphia Medical Journal, March 26, 1904.

^o Philadelphia Medical Journal, May 9, 1903.

diately closed by natural process undergoes granulation with resultant deposition of scar tissue and thus even in the case of very small tears acts as an irritant, which will cause congestion or increase that already present. Aside from retention of secundines no more prolific cause of uterine subinvolution and its morbid accompaniments exists than such lacerations. Then again the gynecologist is fully aware of the amelioration and disappearance of reflex nervous symptoms, which so frequently follow repair of the cervix. *Craig* reports 84 per cent of permanently cured cases with no return in subsequent pregnancies. Improper repair not only predisposes to a relaceration worse than the original tear but, like certain unrepaired lacerations, causes serious dystochia by containing excessive amount of cicatricial tissue.

In this somewhat brief review of the literature we note a consensus of opinion that unrepaired and especially unhealed cervical lacerations are the most prolific cause of subinvolution and secondary displacement and that the formation of scar tissue and its presence is very often responsible for the train of nervous symptoms in the woman, who has borne children. We note also, I think, an increasing tendency to undertake repair work upon the cervix very soon after labor.

There is no doubt that the repair of cervical lacerations of even moderate degree offer advantages to the patient, which cannot be overestimated. While such tears may heal spontaneously in 25 per cent of cases, they do so by granulation and formation of scar tissue, which may give rise to further trouble in subsequent pregnancies and produce a train of reflex symptoms by no means desirable. Due to the fact that even deeper lacerations are often not recognized by symptoms it behooves us to carefully examine each case for such tears just as religiously as we do for perineal tears.

From personal experience the immediate operation offers certain advantages which are greater than those obtained by either the intermediate or the secondary operation, while the objections are largely based upon theoretical grounds and are not borne out by actual experience. The advantages are:

1. Hemorrhage is promptly arrested and normal involution promoted.
2. The chances of infection are certainly lessened.

As regards the infection of the patient during the operation, the oppor-

tunities of such infection are certainly just as great four or five days later, if the technic is faulty. The torn and lacerated surfaces are exposed to the increasing bacterial flora of the later puerperium, with the care of an often untrained and sometimes ignorant obstetrical attendant; not to speak of the discomfort to the patient of later curative treatment by tampons and douches.

3. Sutures remain in position sufficiently long to keep the torn parts approximated until union takes place, for repair in almost every instance is definitely accomplished. One is often surprised by the small size of the loop of a suture removed from the full thickness of the perineum, though introduced when the tissues are swollen and congested after labor.

4. The proportion of cases in which febrile rise occurs is less than where repair work has not been done and does not occur more frequently than in the normal run of obstetrical cases.

5. Suture of moderate tears can be done just as readily as a repair of the perineum, and without assistance if necessary. Deeper tears extending into the vaginal vault present difficulties, which can, however, be readily overcome; the only assistance required is that of the nurse and an anæsthetist. No one nowadays would have the hardihood to leave the giving of an anæsthetic to an inexperienced individual.

6. Bleeding, which may obscure the field, is usually promptly controlled by the placing of several approximation sutures.

7. Not only can recent lacerations be repaired with excellent results, but tears of longer standing can be freshened and sutured with results equally as good if not better than when secondary trachelorrhaphy is performed.

8. The additional time required to repair the cervix even when deeply lacerated is short and the additional amount of anæsthetic is small.

To shorten the time it is often possible to place the perineal sutures before the placenta is expelled. These may be left clamped, and tied after the cervical repair has been accomplished.

In repairing deeper tears the work is greatly facilitated by using a very large Prior speculum which exposes the parts so thoroughly, that the tissues can be readily recognized and no amount of unusual traction upon the cervix is required. In fact, the tissues are often so friable that unusual traction will permit the volsellum forceps to tear through. The method is

briefly as follows: The vaginal floor is retracted by a large Prior retractor such as is used in the performance of vaginal Cæsarean section. The anterior and posterior lips of the torn cervix are caught and held by volsellum forceps. If the tear is an extensive one a smaller Sims speculum is used to retract the lateral vaginal wall, thus exposing the tear. An old laceration is freshened by means of blunt pointed scissors. The first suture is placed about midway, tied and permitted to remain uncut, so that the ends may be used as a tractor. Successive sutures are now placed until the height of the tear is reached; each additional suture is tied and the long ends used as a tractor. When the top of the tear has been sutured these ends are cut and the lower end of the rear united. The opposite side is now exposed in like manner and sutured. One must be careful not to place the sutures too near the lower end of the exposed surfaces so that the normal external orifice be not encroached upon. Where assistance is not available the lateral vaginal wall may be packed off with gauze to expose the torn parts. If perineal sutures have been previously placed they may now be tied or the repair of the perineum may now be accomplished. Ten-day chromocized catgut may be used and after the 12th day daily douches of normal salt solution or compound antiseptic powder may be given.

I see no reason why, after a careful preliminary toilet and with the observance of strict asepsis a clean piece of surgical repair should expose the patient to added danger of sepsis, even at this time. Repair of the tissues at the pelvic inlet is as essential as the repair of the tissues at the outlet, if not more so. There is no question as to the advantage and the success of repairing the perineum immediately after labor, why should there be a question about the repair of the cervix and the vaginal vault?

Involution does not confine itself to the changes in the uterus itself, but has a more far reaching significance when applied to the tearing, laceration and stretching of the structures at the pelvic inlet.

The immediate repair of the cervix not only promotes involution of the uterus but insures a more rapid return to normal of most of the structures, whose integrity is for the time disturbed by the process of labor. The kit of the up-to-date obstetrician should contain the essentials for the prompt repair of the cervix just as it does the means for immediate repair of the perineum.

The gynecologist to-day would be very much relieved to have such minor surgery as the repair of the cervix placed where it belongs in the hands of the obstetrician at the time of labor.

Report of cases:

1. *Mrs. L. K.*—Mother of two children. First labor, low forceps due to uterine inertia. Second labor normal. Third labor in December, 1903, was terminated at the seventh month on account of accidental hemorrhage. Rapid manual dilatation, version, and extraction. On examination a bilateral tear was discovered extending upon one side into the vaginal vault. Fearing hemorrhage immediate repair was done. Puerperium normal, lochia not profuse. Healing only partial, but satisfactory. The urgencies of the case, being in the country, necessitated interference without proper assistance (the nurse giving the anæsthetic), and the repair was done under difficulties. A subsequent labor a year and a half later was normal but precipitate and there was a relaceration of the cervix but not to the same degree. Puerperium slightly febrile; some pain and discomfort directed to the side upon which the deeper tear is situated. Lochia rather profuse and subinvolution. Patient has been more or less uncomfortable ever since. Uterus large and somewhat prolapsed. Secondary repair refused.

2. *B. C., July 2.*—Primipara. P. O. Scanzoni with axis traction forceps. Extensive laceration of cervix, of lateral vaginal wall, and slight tear of perineum. Immediate repair. Puerperium afebrile, lochia moderate in amount, involution good, result good.

3. *K. E., August 18, 1904.*—Ankylosis of right hip due to Potts in childhood. Marked tilting of pelvis, which is generally contracted. Labor pains irregular for three days. Posterior occiput. Manual dilatation. Forceps applied at brim. Considerable laceration of cervix, vagina, and perineum. Immediate repair. Convalescence normal. Tear of one side not completely healed, leaving a small gap. Second child July, 1905. Very small child, normal position, no recurrence of tear.

4. *B. G., January 12, 1905.*—P. O. In hard labor for 24 hours. Scanzoni. Bilateral cervical tear, tear of right lateral wall, slight tear of perineum. Immediate repair. Puerperium normal, afebrile, lochia not profuse. Marked relaxation of pelvic tissues. Examination at end of third week showed excellent result of repair work. Uterus large, involution retarded. Tonics and advised rest. The latter not observed. Six months later, uterus somewhat prolapsed but well involuted and cervix in perfect condition.

5. *N. G., July 24.*—P. O. Scanzoni. Bilateral tear of cervix, of right lateral wall, and irregular tear of perineum. Immediate repair. Puerperium afebrile, lochia scant. Examined at end of third week—involution has progressed normally, uterus in normal position. Lacerations well healed.

6. *A. G., March 31, 1905.*—Normal labor. Precipitate second stage. Bilateral tear to vaginal vault on one side. Immediate repair. Results excellent.

7. *A. H., March 21.*—Primipara. P. O. Scanzoni. Ragged bilateral deep tear of cervix. Immediate repair with good results.

8. *J. B., June 15.*—Frail anæmic woman of small stature. Painful contractions for one month prior to actual labor. Long protracted labor with very

slow progress. L. O. I. A. Five hours after rupture of membranes high forceps. Child weighed 12 pounds. Extensive laceration of cervix, vagina, and perineum. Immediate repair. Puerperium slightly febrile for six days then normal. Convalescence slow. Result of repair good. Some tendency to prolapse for six months, final recovery.

9. A. C., *September 20, 1905*.—Six para. Old laceration of cervix, bilateral with prolapse. Cervix so long that external os projects beyond vulvar orifice, when not pregnant. Normal labor. After delivery the edges of the old laceration were freshened and united. At end of third week union had taken place and uterus but slightly enlarged beyond normal. Previous pregnancies had been characterized by flooding. Lochia normal in amount. Abdominal support and pessary for some months after has made patient very comfortable. Uterus is not prolapsed to former degree, cervix is shorter. Patient has been made comfortable.

10. A. H., *October 1, 1905*.—Medium forceps. Bilateral laceration. Repair with good results.

11. E. M.—First labor four years previous. Medium forceps; large child. Extensive perineal laceration. Cervix not examined. Lochia profuse and continued bleeding for several weeks. Second labor two years ago—normal; no perineal tear. Complained of weight and pressure with some bladder disturbance ever since birth of second child. April 8, third labor—cervical laceration of moderate degree with old scar tissue. Perineum slightly torn. Immediate repair. Anæsthetic pushed too vigorously. Collapse, pulse almost imperceptible. Restored after an hour's hard work. Puerperium subsequently normal. Lochia scant. Result of repair good. Has had no return of former discomfort.

12. E. W., *November 26, 1906*.—Medium forceps P. O. Scanzoni. Immediate repair. Puerperium normal, afebrile. Results good.

13. R. C. T., *November 21, 1906*.—Narrow pelvic outlet. Arrest of head at end of second stage. Forceps. Cervical and perineal tear. Immediate repair with good results.

14. M. B., *March 18, 1907*.—Has retrodisplacement. Medium forceps. Cervical and perineal tear. Immediate repair with good results. After third week Hodge pessary for two months. Displacement corrected and has not returned at present time. Puerperium afebrile, involution good. Lochia normal. Patient anæmic and constitutionally weak.

15. F. R., *July 7, 1907*.—Medium forceps. Deep cervical laceration tear of perineum in median line. Immediate repair. Temperature third day controlled by quinine, subsequently by Warburg's tincture. No recurrence of temperature, which remained normal. Lochia profuse and continued for four weeks. Styptol administered and hemorrhage finally stopped. There was no milk secretion and patient was unable to nurse child. At end of four weeks union of cervix and perineum was found to be good, but uterus enlarged and subinvolved. Metrorrhagia recurred and lasted for two weeks. Has menstruated since. Flow normal. Has had a retroflexion previous to confinement. Hodge pessary introduced and worn for six weeks with good results.

16. M. M.—First child two years previous. Cervical tear not recognized, small tear of perineum repaired. Slight anæsthesia at end of second stage

produced dangerous cardiac symptoms. Further interference refrained from. Subsequent retro-displacement with considerable discomfort. At present labor, which was entirely normal, on examination found bilateral laceration of older date with marked eversion of lips and erosion. Edges of tears were freshened under anæsthesia and brought together with catgut sutures. Puerperium slightly febrile, lochia scant. Some intestinal disturbance; mild toxemia. Examination at end of third week showed that the cervical tears were well healed; very slight patch of erosion at external os. Uterus in normal position and well involuted. Patient has since felt absolutely comfortable.

17. *F. L., February 12, 1906.*—Long tedious first stage. After rupture of membranes with cervix almost fully dilated had hard contractions for six hours, but no progress; well-informed caput succedaneum. Position of head not made out. High forceps attempted; was unable to feel the ear when applying forceps. After prolonged effort at delivery this was despaired of and Cæsarean section suggested but refused. Forceps again attempted and after prolonged and violent efforts delivery was finally accomplished. A tendency to rotate was noticed when head reached the level of ischial spines and this was assisted with the forceps. Head right posterior position. Child weighed 14 pounds and lived three days, dying of cerebral hemorrhage. Had also sustained fracture of left parietal bone. Extensive bilateral laceration of cervix into vaginal vault on both sides. Forked tear of vaginal floor and deep tear of perineum down to sphincter. Immediate repair. Puerperium after first day afebrile, lochia normal in amount. Recovery uneventful. Remained in bed two weeks. At end of four weeks the results of repair work were very satisfactory. Uterus, however, large and displaced to right side. For several months patient complained much of pain on right side and backache. Refused examination. Patient had always suffered greatly from dysmenorrhœa and at time of labor showed marked toxic symptoms, headache, disturbance of vision, and before operation had fallen into a torpor. After delivery menstrual periods returned regularly without pain and with one exception of normal flow. Second labor February 12, 1907—Medium forceps. Child in L. O. I. A. Weight, 10 pounds. Recurrence of cervical tear of moderate degree. Immediate repair. Puerperium normal, lochia scant. At end of third week uterus in normal position, involuted, cervical repair complete. Patient has been absolutely comfortable.

18. *M. F. R., September 20, 1907.*—Primipara. Child, 9 pounds. Medium forceps. Cervical and perineal repair with good results. After fifth day patient had extremely offensive lochia with febrile rise, which continued for several days. On investigation a forgotten gauze sponge was fished from the vagina, when conditions became normal. Recovery uneventful. Involution normal.

19. *Mrs. K.*—First confinement seven years previous. Extremely large child. Extensive lacerations. Profuse post-partum hemorrhage. Repair. (Statement obtained from patient.) Subsequent pregnancies normal. Bilateral lacerations of cervix with formation of much scar tissue. Repeated relaceration of partially-healed cervical tears. Patient anæmic; requiring iron and tonics almost constantly. Menstrual periods profuse and lasting 8 to 10 days. Bleeding during puerperium always profuse and continues for

several weeks after confinement. From beginning of pregnancy to end large varicose veins appear extending to vulva in the latter weeks. Trachelorrhaphy suggested but always deferred. November 5, 1907—Present pregnancy (fifth) normal. After delivery, under anæsthesia, the old lacerations were freshened and sutured with catgut. Puerperium normal and afebrile excepting a brief rise of temperature on fifth day due to congestion of right breast, which quickly subsided upon application of ice and use of breast-pump. Lochia very scant, and practically ceased on tenth day. Examination at end of third week shows absolutely good union of cervical tears. Cervix has the appearance of one that has never been lacerated. Uterus in good condition and much smaller than after previous pregnancies. Patient feels very comfortable at end of fifth week. No return of bleeding, no feeling of weight and pressure. Has mended more promptly and feels more comfortable than after any of the previous pregnancies, when convalescence has always been tardy. Has gained in weight.

20. A. S.—First labor five years previous. Very large child, forceps, extensive laceration. Secondary repair later. Three years ago second labor, large child, forceps. Return of laceration without repair. Third labor May 30, 1907. Pains for two weeks previous to actual labor. Open vaginal examination, external os cannot be made out. The vaginal vault is filled with a mass of irregular tissue, which feels like a bunch of grapes. Actual labor somewhat protracted, but otherwise normal. Large child. Anæsthesia after delivery. Cervix shows three distinct lacerations of older date with some extension of the lacerations higher up. Edges freshened by scissors and sutured. Puerperium absolutely normal and afebrile. Patient kept in bed for 12 days. Examination at end of fourth week shows excellent results of repair work. The tears are perfectly healed and cervix appears absolutely normal. Uterus is well involuted and in normal position.

21. B. K.—First child delivered in Annapolis in 1902. Child large. Forceps with extensive laceration. One month later general repair at U. P. I. Subsequently constant pelvic pressure and backache with inability to control bladder. April 21—11 pound child. Median forceps. Cervical tear and tear of perineum. Complete and immediate repair with apparently good results. Old tears not freshened. Examination six months later shows cervix well healed but great relaxation of pelvic tissues. Prolapse of moderate degree and cystocele. October, 1907—Third child, seven pounds, normal labor. Triple laceration of cervix. Bilateral tear and anterior tear. Immediate repair with removal of old scar tissue. Puerperium febrile about third day. Passed a large odorous clot. Temperature at once became normal. Lochia rather free up to passage of clot, then normal in amount. Examined at end of third week. Uterus well involuted. Cervix absolutely healed. Vaginal tissue relaxed but uterus in better position than after previous pregnancies. At end of six weeks still has good control of bladder and feels decidedly more comfortable.

22. L. M., *March 11, 1907*.—Persistent P. O. Delivered with oxis traction forceps. Bilateral cervical tear, deep median tear of vaginal floor to the bowel and tear of perineum through sphincter to the anus. Complete repair. Examined December 10. Absolutely good union of all tears. Cervix small, uterus well involuted in normal position. Puerperium absolutely afebrile.

RIGOR MORTIS IN INVOLUNTARY MUSCLE.

BY ROY W. LOCHER, CLASS OF 1910.

The subject of rigor mortis in involuntary muscle is one about which there has been considerable controversy; but taking an average of all the arguments, both pro and con, it may be correct to conclude that involuntary just the same as the voluntary variety of muscle, undergoes rigor mortis to a greater or less degree. In making this statement, a great many facts must be taken for granted, for a greater part of the writers on this subject, who, so positively uphold the affirmative, are forced to admit that the condition of involuntary muscle after death has not been definitely determined.

Dr. Brouardel, Director of the Morgue at Paris, a position which gives him a good, if not the best opportunity to study these conditions, states that the muscles of the intestinal wall may undergo rigor mortis to a certain degree; this post mortem condition, as seen in the seminal vesicles, is constant and appears early. In the spleen, is found a typical example of rigor mortis. In the stomach and uterus, this condition has frequently been observed.

The muscles of the heart do not escape this rigidity. Due to the fact that the heart is in a state of contraction or rigidity a good part of its time, most all treatises on medical jurisprudence contain regrettable errors on this subject. The chief dispute has come about because just at the instant of death the heart is either in systole or diastole. In case of systole, many writers, on the negative side, claim that the rigidity observed is due to the systolic action and not to rigor mortis, while on the other hand, in case of diastole, the fact that the heart muscle is relaxed is ample proof that same does not undergo rigor mortis. In spite of these arguments, Drs. Brouardel and Reese claim that, beyond a doubt, the cardiac muscle undergoes this peculiar change. In a number of cases, it has been observed that in autopsies, when the chest cavity is opened, the heart is in a relaxed state, but it rapidly becomes rigid, and in these cases, the cardiac muscle shows a distinct acid reaction. The fact that it is acid, is further proof of its having undergone rigor mortis; it being stated by some of the latest authorities, that rigor mortis is caused, not only by the coagulation of the myosin, but by the formation of a certain peculiar acid. Even this statement has been disputed.

The easiest solution to this much-questioned subject, is that the time at which rigor mortis appears and its duration is so variable and influenced by so many conditions that to make any positive statements is next to impossible. Furthermore, autopsies are rarely held until several hours after death, thus giving the involuntary muscles the best of chances to undergo rigor mortis and again assume their relaxed state.

Nevertheless, nothing has been proven absolutely to the contrary, and as far as investigations have shown, the phenomena of rigor mortis in involuntary muscle are precisely the same as those of the voluntary variety.

(CONTINUED FROM VOL. X, NO. 3, OCTOBER, 1907.)

THE CLIMATE OF NEW MEXICO, NATURE'S SANATORIUM FOR CONSUMPTIVES.*

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LOCALITIES.

The following places have been selected as fair examples of the various portions of the Territory of New Mexico: Alamogordo, Albuquerque, Carlsbad, Deming, Fort Bayard, Fort Stanton, Las Cruces, Las Vegas, Roswell, and Santa Fé. These localities vary in altitude from 3122 feet at Carlsbad to 7013 at Santa Fé. Some are located in close proximity to the mountains and others on the plains. The list might be enlarged very greatly, but the number given is sufficient to illustrate fairly well the various climatic conditions to be found within the borders of New Mexico.

ALAMOGORDO.—Alamogordo, in Otero County, elevation 4500 feet, is located on the main line of the El Paso-Rock Island Route, 86 miles north of El Paso, and only a few miles west of the foot hills of the Sacramento mountains, which rise to an elevation of about 9000 feet. It is a town of about 4000 inhabitants, electrically lighted, and supplied with an abundance of pure water, which is piped from springs in the mountains some fourteen miles distant. This town less than ten years ago was a desert, but since the advent of the railroad, and by

* Reprinted from the New York Medical Journal for July 6, 1907.

means of irrigation great numbers of shade and fruit trees have been grown, and it is now one of the most attractive towns in the south central portion of New Mexico. A large sanatorium is now in course of erection just outside the town toward the mountains. One very desirable feature of this locality is the availability of any desired altitude from a little over 4000 feet to as much as 9000 feet within a few miles. The mountains afford protection from the severe winds, and while the summers are warm, the temperature having reached as high as 109° F. during the past five years, the winters are very delightful; the lowest temperature recorded for the same period has been 8° F. above zero. The greatest number of cloudy days recorded in any one year since 1902 was 27, and the number of absolutely clear days has ranged well above 225. A temperature of 109° F. seems in figures very high, but when the absence of humidity is remembered it will be easily understood that such a temperature is by no means attended with any considerable discomfort. For the same reasons comparatively low temperatures are experienced without suffering. The minimum temperature occurs about 3 or 4 o'clock a. m., and the temperature will rise quickly twenty or thirty degrees, or even more, shortly after sunrise. The average precipitation, except during the past two years, was about eight inches, and while I have no exact data as to humidity, it is unquestionably very low.

ALBUQUERQUE.—Albuquerque, in Bernillo County, central New Mexico, is the most considerable town in the Territory. It is situated on the main line of the Santa Fé Railway, in the Rio Grande valley, at an altitude of 5200 feet. The valley of the Rio Grande at Albuquerque is quite wide, and the town has, therefore, less protection from the winds than some others, although the weather bureau does not furnish accurate observations on this point. It has long enjoyed an enviable reputation as a resort favorable to consumptives, and the hotel accommodations are good. Malarial fever prevails to some extent in parts of the town lying in close proximity to the river. The population is perhaps 15,000, and there are such modern conveniences as street cars, electric lights, water works, gas, and sewers. The annual rain fall is between seven and eight inches, and the mean annual temperature is 55.7° F. Within twenty-five miles there are the mountain resorts of Whitcomb

Springs, Coyote Spring, and Devil Cañon, the last being a popular camping ground.

CARLSBAD.—Carlsbad, a growing and prosperous town in the Pecos valley, has an altitude of 3122 feet. All this region is developing rapidly, mainly by reason of the excellent supply of artesian water, which is extensively used for irrigation. The winters are warm and pleasant, the mean minimum temperature of 43° F. occurring in December and January, while the mean annual temperature is 63° F. The mean annual precipitation is about twelve inches. The climate of Carlsbad, while excellent in winter, is rather too warm for consumptives in summer. Carlsbad is on the Pecos Valley & Northeastern Railroad, a branch of the Santa Fé system, and derives its name from springs having essentially the same mineral constituents as the celebrated German springs of that name.

DEMING.—The town of Deming in southwestern New Mexico is one of the moderately high altitude locations, is situated on a plateau some forty by fifty miles in area, west of the Rio Grande valley, and is the junction point of the Southern Pacific and Santa Fé railroads. Its altitude is 4331 feet, and the mean temperature arrived at from a period of twelve years' observations is 70.2° F., and the annual rain fall is 8.79 inches. Deming has a very favorable winter climate for tuberculous patients, and its water supply has long been famous. The principal hotels and restaurants in El Paso, Texas, until recently, offered the use of Deming water as an attraction. Owing to the situation of Deming on a plateau with the surrounding mountains some twenty miles distant, the prevalence of winds and sand storms during the spring months is to be expected, but as a winter resort for consumptives its reputation is well deserved.

FORT STANTON.—The Reservation of Fort Stanton embraces nearly forty-five square miles, through the center of which, from west to east, flows the Rio Bonito. The buildings are located on the south bank of the Bonito, almost exactly in the center of the reservation, at an altitude of 6231 feet. Five miles to the east are the Capitan mountains, between nine and ten thousand feet above sea level, while to the westward rise the foothills of the White mountains, culminating in White Mountain Peak, which has an altitude of 11,976.5 feet above sea level. On the north

and south the sanatorium buildings are sheltered at a distance of about one-half mile by hills, which rise from three to six hundred feet above the level of the parade ground around which the buildings are clustered, so that the sanatorium proper is very much protected against high winds and sand storms. This protection by the surrounding hills is very noticeable when on a windy day one rides across the hills to the neighboring towns.

The Rio Bonito furnishes the station with an ample supply of very excellent water, both for domestic purposes and irrigation during the greater portion of the year; when the river supply fails, water of good quality and very soft is pumped from deep wells.

The average number of clear days annually is 173, partly cloudy 140, and cloudy 52, using the nomenclature of the weather bureau. Precipitation occurs on an average of seventy days in a year, and the annual precipitation is about seventeen inches. The average relative humidity is 53 per cent, the mean maximum temperature 65° F., the mean minimum 38° F., and the annual mean is 52° F. The highest temperature recorded during a period of twenty-eight years was 95° F., and the lowest temperature recorded in the same length of time was -18° F., which occurred on December 22, 1887. The average hourly wind velocity is 6.6 miles, and the highest velocity ever recorded was 63 miles, which occurred during the month of May. The average annual snow fall is 22.3 inches, which, of course, is included in the total average precipitation. The average date of killing frost in spring is May 6, and the average date in the autumn is October 5.

These statistics are taken from the records made during the occupancy of Fort Stanton as an army post. My own observations during the past six years indicate a larger number of clear days and fewer cloudy days, as well as rather less precipitation, but as these observations were made by an amateur and cover a shorter period, they are probably less reliable than those supplied by the weather bureau. The occurrence of temperature below zero is very rare, and equally rare is the maximum summer temperature.

Fort Stanton is not a town, but solely a government sanatorium maintained for the reception of tuberculous patients, who are beneficiaries of the Public Health and Marine Hospital Service, but about

ten miles distant is the quaint old town of Lincoln, the county seat of Lincoln county, and having a population of about 700 people. Here one of my former assistants, himself a recovered consumptive, has located on a fruit farm, where he has established a private sanatorium, and he has an increasing number of patients whose favorable progress is most gratifying.

FORT BAYARD.—Fort Bayard, in southwestern New Mexico, is too well known as the location of the Army General Hospital for the treatment of tuberculosis to require more than passing notice. It is situated about nine miles from Silver City at an altitude of about 6100 feet. The climate of Fort Bayard is practically the same as that of Fort Stanton; the temperature is slightly higher, while the winds and other climatic data register about the same. Silver City profits by the advertisement of the proximity of Fort Bayard, and has established two or three sanatoria for the treatment of consumptives. The town of Silver City, located in the midst of an active mining country, has a population of about four or five thousand, is reached by a branch of the Santa Fé, and is a growing and attractive point to which invalids resort.

Fort Bayard is not open to the general public, being maintained exclusively for the reception of tuberculous officers and men of the army, but there are three sanatoria maintained in the nearby town of Silver City, where the climatic conditions are the same as at Fort Bayard.

LAS CRUCES.—Las Cruces, Dona Ana County, in southern New Mexico, is located on the main line of the Santa Fé Railway in the Mesilla valley, a name given that portion of the Rio Grande Valley extending from the Selden mountains on the north to within a few miles of El Paso, Texas, where the river flows through a range of mountains. The entire length of the Mesilla valley is about fifty miles and the average width is about five. The Organ mountains, about ten miles east of Las Cruces, rise to an altitude of from seven to nine thousand feet above sea level. The observations for Las Cruces are taken at Mesilla Park, about two and a half miles southeast of the town, this being the location of the experiment station, as well as one of the territorial colleges. Its altitude is 3868 feet. The mean maximum temperature is 76.8° F. and the mean minimum 41.4° F., while the annual mean is 61.6° F. The highest recorded temperature is 106° F., and the lowest 1° F.

below zero. The average annual precipitation is slightly under nine inches, and the mean annual relative humidity is 51 per cent. The average number of clear days is 225, partly cloudy 91, and cloudy 49. The mean annual average wind movement is 6.7 miles per hour. Owing to the considerable distance of this valley from the mountains on the west the wind storms in spring are of greater frequency and severity than in the more mountainous parts of the Territory. Winds reaching a velocity of seventy-five miles per hour have been recorded, but, as in other portions of New Mexico, storms of a cyclonic nature are unknown. The prevailing direction of nearly all the high winds is from the west, and such winds usually carry considerable quantities of sand and dust. There are occasional high winds from the south, which, when they prevail for two or three days, are usually accompanied by cloudiness and often rain. Las Cruces and the Mesilla valley have a delightful winter climate, and it is chiefly during this season that it is especially adapted to the needs of the consumptive.

LAS VEGAS.—Las Vegas, San Miguel County, north central New Mexico, about forty-five miles east and ten miles south of Santa Fé, is one of the most beautiful and attractive cities in New Mexico. It is located on Gallinas creek in a rolling hilly country at the base of the Gallinas mountains, and is on the main line of the Santa Fé Railway. Its altitude is 6384 feet. A few miles up the valley from Las Vegas are the celebrated Gallinas Hot Springs. On the west and northwest the mountains rise to an altitude of 9500 feet and afford protection from the prevailing winds. Las Vegas has an excellent water supply, good natural drainage, and all the modern municipal conveniences. Its refined social life, and the natural beauty of the surrounding country, as well as its superior climate, attract many tourists and invalids.

The number of clear days annually is very large, 227 being the average; partly cloudy, 115; and cloudy only 23. Precipitation occurs on an average of 67 days, with an annual average of about nineteen inches, and a relative humidity of only 50 per cent. The mean maximum temperature is 65° F., the mean minimum 36° F., and the annual mean 50° F. The highest temperature recorded for a period of nineteen years was 98° F. in June, 1902, and the lowest 31° F. below zero in February, 1905. It will be observed that the climate of Las Vegas is colder in

winter than that of either Santa Fé or Fort Stanton. The data as to winds are not at hand, but the location of Las Vegas with reference to the mountains indicates comparative freedom from winds of great velocity.

ROSWELL.—Roswell, the principal town in the Pecos valley, is located on the Pecos River in southeastern New Mexico at an altitude of 3570 feet. It is a town of about 7000 people, and is the site of the New Mexico Military Institute.

Roswell and the Pecos valley, generally, are celebrated for artesian wells, and this region is one of the finest agricultural and fruit growing sections of the southwest.

Being located in a wide valley which stretches far to the north as well as to the south, Roswell is exposed to high winds, and being of comparatively low altitude its summers are hot, while the winters are usually mild, although an occasional northern wind brings heavy snow and low temperature.

A maximum temperature of 101° F. is recorded, and a minimum of —31° F. The average for the year is a little over 59° F., and the average precipitation about sixteen inches.

Roswell is only seventy-five miles from Fort Stanton. Its numerous lagoons and streams are the resorts in winter of thousands of ducks, while fishing is good the year round, and, like Carlsbad, it has an excellent winter climate for consumptives. Many invalids spend the winter in the Pecos valley, and during the summer make camping trips to the White mountain region near Fort Stanton.

SANTA FÉ.—Santa Fé, the capital of the Territory, and perhaps the oldest town in the southwest, is situated in the mountainous region of north central New Mexico. Its altitude is 7013 feet, and it is protected on all sides by mountains, and possesses one of the very best high altitude climates in New Mexico.

Santa Fé possesses considerable interest for the tourist, and it was here in the ancient Governor's Palace that General Lew Wallace wrote *Ben Hur*. The climatological data of Santa Fé, kindly furnished me by Mr. C. X. Linney, section director, United States Weather Service, are very complete, as well as interesting and valuable, and will be added to this article in their entirety as an appendix. They show a very large

number of clear and partly cloudy days, and an average precipitation of less than fifteen inches; average humidity of 45 per cent, and an average hourly wind velocity of 6.9 miles, with the highest hourly velocity of fifty-three miles, which was recorded in October, 1906. The percentage of sunshine annually is 76 out of a possible 100. In order that you may more thoroughly appreciate the meaning of this proportion I may say that Boston has 55 per cent, Buffalo 49, New York city 56, Pittsburgh 44, Philadelphia and Washington 57, Detroit 52, St. Louis, Jacksonville, and Des Moines, each, 60, Cincinnati 38, while Atlanta, Ga., the highest of which I have secured any record, has but 61.

Santa Fé has a population of about 10,000, and not only is the city itself picturesque and attractive to the tourist and invalid, but the surrounding country abounds in scenic, prehistorical, and historical attractions, among which is the cave dwellers' region in Pajarito park, only a day's journey distant over land. Three railroads enter the city, the Santa Fé system, the Denver & Rio Grande, and the Santa Fé Central. A tent city sanatorium is maintained near the town.

EL PASO, TEXAS.—El Paso, although located within the commonwealth of Texas, is situated in that part of the State which is naturally a portion of New Mexico.

It is the gateway to New Mexico from all the Gulf States, as well as from California. Its altitude is 3767 feet, with a climate very much the same as that of Las Cruces.

Great numbers of tourists and invalids resort there in the winter months, and many of its most prominent citizens, who came from all parts of the United States, first came to El Paso as health seekers.

El Paso is a wide awake, modern, and rapidly growing city of about 50,000 people, and is a convenient and attractive resting place for invalids en route to New Mexico.

A WORD OF ADVICE TO PATIENTS INTENDING TO RESORT TO THE SOUTHWEST.

A word as to the character of cases for which the climate of New Mexico is best suited may not be amiss; this may be better expressed by enumerating those who should not seek it.

1. Consumptives should not come to New Mexico without sufficient

means to procure the necessities and even the luxuries of life, chiefly because most of them are not fit to engage in the struggle for a living, and, secondly, because there are many more applicants for work than places. As a rule consumptives need rest, and then more rest, while undue exercise has caused many deaths which have been attributed to altitude.

2. Patients with advanced valvular heart disease do not do well in high altitudes, and those who by reason of the great extent of lung tissue involved, or for other reasons, have a low vital capacity as shown by small chest expansion, would do better to reach a high altitude by gradual stages, or before coming, to increase their breathing capacity by appropriate chest expansion exercises; although the earlier the diagnosis is made and the more prompt the resort to appropriate climate, the greater the probability of cure, still far advanced cases, especially if with no serious complications, frequently do well. I have just discharged a half dozen such patients apparently cured, which have been under treatment three to seven years, and one of these had also a very heavy albuminuria which likewise disappeared.

A tendency to hæmorrhage is not a bar to residence in high altitudes; indeed the statistics of the Fort Stanton sanatorium show that there is less probability of hæmorrhage at 6000 feet than at sea level, and many patients with laryngeal tuberculosis recover perfectly.

SUMMARY.

To summarize, New Mexico, as a resort for consumptives, has the following advantages: (a) Altitude; (b) low relative humidity; (c) large percentage of sunshine, advantageously distributed as to season; (d) cold or cool nights; (e) moderate wind movement; (f) small precipitation; (g) rarity of fog; (h) pure air; and (i) well drained soil with low percentage of soil moisture.

In conclusion I quote from Climatology of the United States, *Bulletin Q of Department of Agriculture*, by Professor Henry: "In general, the climate (of New Mexico) is such as to permit outdoor work and outdoor life the year around under conditions that are comparatively comfortable and pleasant. The windstorms that prevail during February, March, and April are the only serious drawback to the climate, which otherwise presents comfortable and healthy conditions the year around."

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

DIAGNOSIS OF CARCINOMA OF THE UTERUS.

When a woman forty years of age or over bleeds excessively at her regular periods, or commences to bleed after the menopause has been definitely established, it is the common practice among the laity and also among the physicians to attribute this unusual flow to "the change of life." The popular belief in this pernicious doctrine is due to the faulty teaching of the public by the physicians. And it is up to the physicians to correct the error and to teach the people that an excessive flow from the uterus always means that there is some pathological lesion that is the cause of it. The three most common causes of bleeding from the uterus at about the period of the menopause are, carcinoma of the cervix or body of the uterus, submucous fibroids, and hypertrophic endometrium.

The fibroid can usually be made out by palpation. The carcinoma of the cervix can in most cases be recognized by its appearance and the sensation it gives to the examining finger. The carcinoma of the body of the uterus and the comparatively innocent hypertrophic endometrium can be differentiated from each other only by curetting the uterus and examining the scrapings microscopically.

All cases of bleeding from the uterus about the time of the menopause should be investigated at once. This investigation should include a

curettment and a microscopical examination of the scrapings. All physicians do not have the facilities for all of this work. But any physician can curette a uterus, and any one can put the scrapings in a ten per cent formalin solution and mail them. Any alumnus who will send his scrapings to the Editor of the JOURNAL can have them examined microscopically. Now get busy and let us see how many alumni will find an early carcinoma of the uterus before the next issue of the JOURNAL.

Obituary.

DR. EDWARD J. JONES, '92, died at his home, New Hampden, Va., November 19, from nephritis.

DR. HUGH M. LOGAN, '79, died October 14, at his home at Rileyville, Va., after a long illness, aged 49.

DR. FRANK W. KRUM, '93, was found dead in a bath room in his offices in Reading, Pa., October 14, aged 35.

DR. PETER O. WICKERT, '82, died at his home, South Bethlehem, Pa., November 19, after an illness of four months, aged 50.

DR. ROBERT COCHRAN BEATTY, '82, for fifteen years a practitioner of Pittsburg, Pa., died at his home in that city, August 25, aged 51.

DR. THOMAS W. SMITH, '76, resident physician at Bethel Military Academy, Va., for thirty years, died at his home near that place, from peritonitis, November 27, aged 52.

DR. HALLY M. WENNER, '92, for several years school director and registrar of vital statistics at Plymouth, Pa., died at his home in West Nanticoke, Pa., November 12, of pneumonia, after an illness of one week, aged 41.

DR. CHARLES BRET POOL, '93, a member of the Massachusetts and Middlesex County medical societies, of Lowell, Mass., died from hemor-

rhage of the stomach, at a hotel in Lowell, while returning from a professional call, aged 38.

DR. JOHN G. CAMPBELL, '79, located in Homer City, Pa., in 1885, and practiced there until the time of his death. In 1904 he had a stroke of apoplexy, and after that was able to do only office work; on October 2, '07, he had a second attack and was helpless from then until he died October 10. He left three children, two daughters and one son.

DR. OTEY Y. WARREN, '85, for 10 years superintendent of the Montana State Insane Asylum, Warm Springs; for two years a member of the legislature; in 1906 president of the Montana State Medical Association; local surgeon for the Northern Pacific and Chicago, Milwaukee & St. Paul railroads at Butte, died at his home in that city, October 19, from heart disease, aged 47.

The following members of the class of 1879 are either dead or we are not able to locate them: Judson H. Booker, Va.; John G. Campbell, dead; M. P. Coates, dead; W. F. Cook; Rev. Thos. Drumm; Dan. T. Ellis; Geo. Fisher; B. A. Guyton; Chas. S. French, dead; Andrew Guiler, dead; Jos. C. Hall, dead; J. T. Harris, dead; Robert L. Hester, dead; Millard Hinerman; Thos. M. Hughes; Abel B. Huntley; Napoleon Kinker; Jos. N. Latimer, dead; Jno. S. Lewis; S. W. Lincoln, dead; J. T. Martin; F. C. McGraw; Hugh M. Logan, dead; Chas. H. Mitchell, dead; Wm. M. Murphy; Geo. Parkse; L. S. Pritchett, dead; N. W. Reeves; Wm. Rickert, dead; Willie S. Spinner; J. W. Stephenson; J. F. White; Jno. E. Williams; Calvin K. Young.

NATHANIEL GARLAND KEIRLE, JR.

It is with great regret that we chronicle the death of one of the most gifted of the younger men about the college and one who was well known by the students who have attended the college during the last decade.

Dr. Keirle was the son of Nathaniel G. Keirle, the Professor of Medical Jurisprudence and the head of the Pasteur Department of the college. He was born in Baltimore, and was educated in the public schools and after a brief trial at mercantile life studied medicine at the college and

received his degree in 1897. After he was graduated he was appointed one of the physicians at Bay View Asylum and later he went to the Hebrew Hospital as Resident Physician in charge of the hospital. After a term of service he left that institution to go abroad and study. He divided his time whilst abroad between London, Berlin, and Paris, devoting his energies to the study of the diseases of the rectum, which line of work he made his specialty. He also studied at the Pasteur Institute in Paris, taking a thorough course in the preventive treatment of rabies. On his return to Baltimore he was made chief of his father's laboratory in the Pasteur Department, which position he held until his death. He also started in the practice of medicine, having an office of his own on West Franklin Street, and being associated with Dr. J. W. Chambers in his surgical work. Later on he devoted his entire time to his own practice. Had he lived his friends all expected him to take a high place amongst the prominent physicians of Baltimore.

Dr. Keirle was an Elk, a member of the Arundel Boat Club, and of the Baltimore Athletic Club. He was devoted to out-door sports and was especially fond of boating and long-distance swimming. He was a most devoted son, and he and his father were boon companions, the relationship being more that of chums than of father and son. They had many tastes in common and were together a great deal of the time. Dr. Keirle was a staunch friend and was ever ready to aid those about him and he was most considerate of the feelings of others.

He was buried from his old home on West Lexington Street, the Elks having charge of the services and using their ritual.

Marriages.

DR. J. CHARLES MADARA, of Ridgely, Md., was married to Miss BERTHA MAY BARRY, of Baltimore, December 3, 1907.

DR. THOMAS W. EDMUNDS, '07, and Miss MASIE LEE CONCANNON were married October 20 at Richmond, Va. Dr. Edmunds has charge of the Mecklenburg Sanitarium at Chase City, Va. Mrs. Edmunds is a graduate of the City Hospital Training School for Nurses.

Correspondence.

December 27, 1907.

EDITOR JOURNAL OF ALUMNI ASSOCIATION.

Will you kindly insert the following in your journal giving it as prominent a place as possible?

The writer desires information regarding any alleged recoveries or cures of inoperable or recurrent carcinoma of the mammary gland.

If any case or cases are known to anyone who reads this circular and can be authenticated by facts as to the history and condition prior to recovery and the length of time which has elapsed since recovery such information will be much appreciated and duly acknowledged.

Any well-authenticated reports of recoveries from carcinoma located in other parts than the mammary gland will be welcomed.

Cancer paste cures, X-ray cures, radium cures, or cures as result of surgical operation are not wanted.

Hearsay cases are not wanted unless accompanied by name and address of the person who can give knowledge first hand. Address,

HORACE PACKARD,

470 Commonwealth Ave., Boston, Mass.

STATE HOSPITAL, ST. PETER, MINN., Nov. 30, 1907.

My Dear Doctor Bevan.—I arrived here on Monday, found the town to be small (about 5000), but modern. The financial stringency is, however, very noticeable out here.

The institution is old, but very modern in its arrangement, accommodating about 1000 patients, having its own laundry, bakery, and manufacturing its electricity, etc. Equipped with theater (also used as chapel and lecture hall), and pool tables for the use of the patients. Separate building for the tuberculosis cases, nurses home, etc.

There are about 150 nurses, both male and female; a gent. head nurse on each side and one in each department. We are supposed to assist in their training with lectures.

The staff is composed of the superintendent, Dr. Tomlinson, a very able and competent man. Three men and one woman physician as assistant. One of the men is a University of Minnesota graduate and has done hospital work in St. Paul. The other is a Georgetown University man (Washington, D. C.). He has been in the New York hospitals. The woman is from Chicago.

There is a promise of good social life. The work is divided among the staff. I have about 250 patients, mostly chronics, and all acute cases, occurring among the old patients. Also the tuberculosis cases.

We report to the superintendent at 12 each day all of the interesting things that happened in our wards during the day. We each have a large office on the first hall, and are well housed. I share with the pathologist two large bed rooms, sitting room, and private bath. The buildings are all well furnished.

There are now two operating rooms and a large one in process of completion, with a surgical ward attached. The Mayo Bros. do the majority of work done here.

We have several cases of typhoid fever and general surgical conditions.

There is at present an epidemic of small pox throughout the State and we have had a number of cases here; it seems to be, however, of a very mild character, and none of the cases are confluent.

Summing it all up I think the time will pass very well.

The book-keeper tells me that there were between 75 and 80 applicants for the position.

Doctor, remember me to my friends there. Regards to Dr. Chambers. And please accept my hearty thanks for your past kindnesses. Believe me to be,

Very sincerely yours,

WM. A. DORSEY.

BUCKHANNON, W. VA., Nov. 25, 1907.

DR. CHARLES E. BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find check for \$2.00 for the ALUMNI JOURNAL, which has been such a welcome visitor to my table. I hope you will excuse my neglect in not remitting sooner.

How eagerly I scan the pages of each JOURNAL to see if any of the class of '97 are mentioned. It is now ten years since we were all together. I have been in active practice in the mountains of West Virginia ever since I left the P. and S.

I was back in Baltimore a few days last fall, and attended one of Prof. Chamber's clinics and heard him lecture, which reminded me of old times.

I would love to hear from any of the boys of the class of '97. They are quite widely scattered, and some are gone to their final reward. I was pained to learn during the past summer that M. T. Gaffney, of New Jersey, one of my class, was dead. Also sad to know that the well-beloved and respected Dr. Latimer had answered to the death summons.

My room-mate, Dr. V. W. Dunlap, is practicing in the southern part of this State. I scarcely ever hear from him any more. Oh! I often think of Gage, Knowls, Cloonan, Kilburn, Bickerstaff, Blanchard, Horton, Barry, Findel, Hudson, and a score of others, and wonder where they are, and how they are getting along.

Boys, could we not arrange and have a reunion some time soon, before our number becomes less.

Fraternally yours,

W. H. GRIM.

RAGAA, BAHREL GHAZAL, SUDAN, Oct. 27, 1907.

THE DEAN OF THE COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE, U. S. A.

Dear Sir.—I have many times thought of sweet Baltimore and of my dear professors and college and the many delightful hours I spent in its circle and among such lovely people and bright nation. I call it one of my sacred duties to show my gratitude to my teachers and professors. "Be obedient to all that teach you a word" goes our proverb, beside I think it a professional duty to post you on the state of our tropical climate.

I should not pass without a word of information (which I am sure swells your heart with joy) as to the work of your graduates. Of your former students, Dr. Nashaty and his brother are getting on nice, one in

venereal diseases and the other on eye diseases. Dr. Fahmy is general practitioner and is doing fairly well, though he does not care so much as the case is with all rich people. Dr. Hanna is appointed in the Egyptian health department. Dr. Kansel was appointed in the Insane Asylum of Cairo, and after two months service resigned his post and is working in few places on his own expenses and is doing good. Myself have been appointed in the Egyptian army with a rank of first lieutenant, and have lately transferred as S. M. O. to this station on the borders of the British, French, and Belgian frontiers for one year service, which after taking my furlough next summer on four months leave (which I hope to spend in America), I will return to our headquarters at Khartoum.

Dr. Laham has been lately appointed in our army with the same rank. The daily work and routine in the hospital is in two forms, military and medical, as we have to go through all forms of military law and order and attend our medical duties day and night. The general diseases in Cairo and Egypt are well known to you all more or less; have met some of them in America, except the ankylostoma and bilharzia, which are very common in Egypt, but in the Sudan we have the following common diseases: malaria, dysentery, guinea worm, leprosy, and varieties of skin diseases, which are very interesting to study, especially on the dark skin of the Sudanese. In my station especially I have the most rare diseases of the world. First and most important the sleeping sickness, which is attacking our boundaries, and a department of our work is studying its problem with the French and Belgian. I hope to give you full information about it when I see you next and will bring you some of the tsetse fly which carry the disease. Next, the blackwater fever, and is very bad, too, but we know how to treat it fairly well. Then we have malaria very general and common, and I have treated a case of ainhum to success and hope to take his photograph and bring it with me. The medical world is quite large and open to all, except you meet great hindrance and difficulties in treating the natives, for they cannot realize your work and they are afraid of it and want to keep to their own treatments. I will be glad to get you any information you like and desire most to know, and hope to make the work quite interesting when I tell you of the Sudan and its people. Our rainy season is almost at an end and the beautiful winter cold is coming. I think I have

written enough for the present and I wish you kindly to give my professors and students my congratulations for many returns of merry Xmas and happy New Year, and beg to remain,

Yours truly,
N. J. KARAGULLA.

READING, PA., August 14, 1907.

DR. C. E. BRACK, Baltimore, Md.

Dear Doctor.—Yours of 12th received, enclosing receipt, also inquiring as to F. M. & T. E. Krum. Dr. T. E. was a class mate of mine, but is not in general practice. Does an advertising business and runs a route from town to town, making periodical calls as per ads. Don't see his often. F. M. I think is a broker, not located here, and not of the '86 class.

Can you tell me when notice of Dr. Bowman's death was published; never saw it.

Dr. Bortz, of '86, is still in practice three miles from the city, at a small country place called Jacksonwald, but nearly all in from drink. Glad to hear of Harry Friedenwald doing well.

With best wishes to P. & S. and all connected therewith, I remain,
Fraternally,

J. C. KNAUER.

CHARLESTON, W. VA., August 19, 1907.

DR. CHAS. EMIL BRACK, BALTIMORE, MD.

Dear Doctor.—In running through some of my papers I find the enclosed reminder which is self-explanatory, especially when accompanied by a check. I enclose the check.

Had a delightful and profitable visit of twelve days with the Mayos in April, followed by a delightful two weeks in the Rockies. My digestion has been good ever since, and I have been able to "Love my enemies," if I have any.

Very truly yours,
A. A. SHAWKEY.

THE SERUM TREATMENT OF EXOPHTHALMIC GOITRE.

Harriet C. B. Alexander¹ discusses the subject and reports thirteen cases. Four principal theories of the disease have been advanced: (1) That it is due to disease of the sympathetic nervous system; (2) that the seat of the malady is the medulla oblongata; (3) that it is primarily a disease of the thyroid gland; and (4) that it is a neurosis.

Modern therapeutic measures have been largely based on the "thyroid" theory. The results of partial strumectomy indicate that the successful removal of a portion of the thyroid gland can lead to cure or to definite amelioration of the condition. On the theory that the thyroid secretion normally neutralizes certain general metabolic poisons in the body, Moebius and others conceived of treating cases of exophthalmic goitre, in which there is presumably an excess of thyroid secretion in the body, by introducing subcutaneously, or by the mouth, the serum of thyroidectomized animals. It was hoped that the non-neutralized general metabolic poisons of such animals would nullify the toxic effect of the aggressive thyroid secretion. As to the treatment, experience has shown the great importance of general measures: complete rest for a time, fresh air, careful diet, mild balneotherapy, etc.

The name Thyroidectin has been given to a preparation obtained under aseptic precautions from the blood of animals from which the thyroid glands have been removed, and which is exhibited as a reddish-brown powder contained in capsules, usually five grains each. Carefully conducted clinical trials seem to show that Thyroidectin can be depended upon to control the characteristic symptoms of exophthalmic goitre. In most cases the patient experiences much relief from the restlessness, tremors, insomnia, and other nervous symptoms so frequently present, and a gradual lessening of the frequency of the pulse-rate, decrease in the size of the glands, and a diminution of the exophthalmos, with an increase of weight and a much better condition generally. The dose of Thyroidectin seems to be one or more capsules after each meal, according to the judgment of the physician and the reaction of the patient.

In nine of the author's thirteen cases the size of the gland was materially reduced, and in every case improvement was observed with respect to one or more of the symptoms.

¹ The American Practitioner and News, August, 1907.

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Vol. XI No. 1

APRIL, 1908

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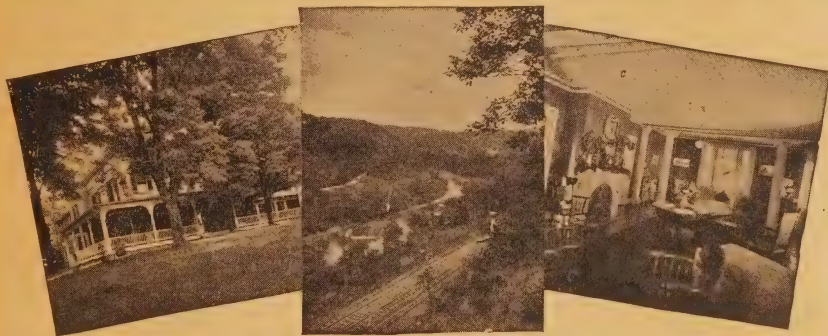
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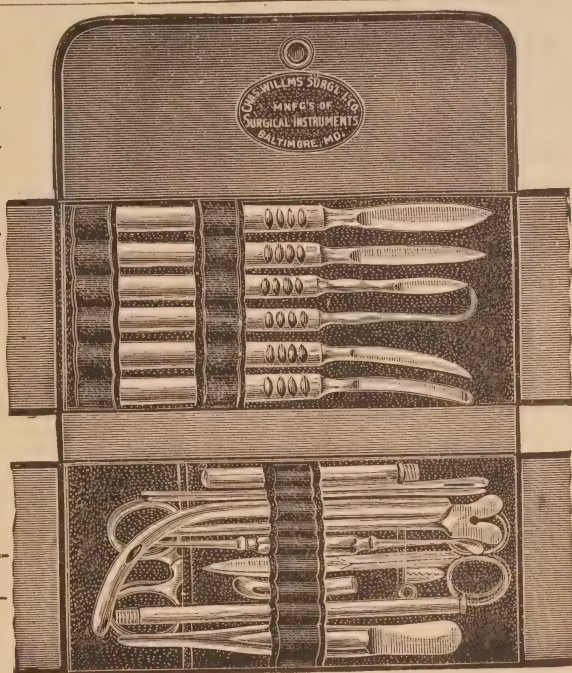
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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

DR. ISAAC RIDGEWAY TRIMBLE.

DR. I. R. TRIMBLE died February 24, 1908, at 12.10 o'clock in the morning, at St. Joseph's Hospital, after an illness of several weeks.

Dr. Trimble was operating on a case of infected kidney at St. Joseph's Hospital on Monday, February 10. Two slight wounds were inflicted on the fingers of his left hand; the cuts were sterilized and little attention paid to them. The following day he had considerable constitutional disturbance and some fever, but on Wednesday he was practically well again, and remained free from fever the whole day. Late Wednesday night his arm began to pain him, and early the next morning there was a consultation of physicians, Drs. W. S. Thayer, F. Martin, A. C. Harrison, and John Ruhrah. The arm was swollen above the elbow nearly up to the shoulder, was very painful; temperature about 104°. It was decided that the arm should be opened immediately, and he was taken to St. Joseph's Hospital, where Dr. Martin, assisted by Dr. Harrison, operated upon him. Following the operation there was some improvement, but a few days later it was found necessary to open the arm a second time. The thing progressed fairly satisfactorily until February 22, when there was a decided turn for the worse and the patient's condition grew very alarming. February 23 there was a sudden collapse in the morning, from which Dr. Trimble did not rally, and went steadily down hill, dying, as noted above, just after midnight.

Dr. Trimble was born at Wye House, in Talbot County, the beautiful country seat of the Lloyd family, and the home of his mother. He was the son of David Trimble and a grandson of Isaac Trimble, who won

quite a reputation for himself during the Civil War. Both the Trimbles and Lloyds are among the oldest families in Maryland, and are widely connected with all the prominent families of the Eastern Shore, having been closely united for several centuries with the development and the social life in that part of Maryland. The first part of Dr. Trimble's life was spent upon a farm, and his college education was obtained at the Shenandoah Valley Academy. After leaving the Academy, he took some short courses at the Johns Hopkins University, and then entered the University of Maryland School of Medicine from which he was graduated with honor in 1884. After his graduation he entered the University Hospital as resident physician and remained there for four years. He then opened an office on Eutaw Street with Dr. Frank West, and had there sort of a private sanitarium. At the time of the construction of the Belt Line Tunnel of the Baltimore and Ohio Railroad he was made surgeon to the company, and during the entire period of construction he looked after the work for the McDonald-Ryan Contracting Company, treating most of the cases and doing many of the smaller operations at his office, which at that time was upon Franklin Street. Later on, when the Baltimore & Ohio Railroad reorganized their medical service, he was appointed chief surgeon in place of Dr. Tiffany, who had resigned his position when he retired from practice. From 1889 to 1899 he was assistant surgeon of the Fifth Regiment of the Maryland National Guard, which position he filled with marked ability. He was also chief surgeon to the United Railroad Electric Company of Baltimore, to the Maryland Casualty Company, and to other casualty companies doing business in Baltimore, besides was examiner for a number of insurance companies.

As a teacher, his work was along the line of anatomy and operative surgery. From 1891 to 1899 he was professor of anatomy and operative and clinical surgery at the Woman's Medical College, in Baltimore, and was dean of the same college from 1894 to 1896. In 1896 he was appointed lecturer on clinical surgery in the University of Maryland, which position he held until 1899, when he was made professor of anatomy and clinical surgery in the College of Physicians and Surgeons; this latter position he held up to the time of his death.

He was a member of a number of medical societies and associations:

Of the Baltimore City Medical Society, the Medical and Chirurgical Faculty of Maryland, the American Medical Association, the Southern Surgical and Gynecological Society, the Association of American Railway Surgeons, and was a member, and at one time president, of the Association of Surgeons of the Baltimore & Ohio Railroad. He was one of the members of the Journal Club and the Medical Reunion, two of the most exclusive medical clubs in Baltimore.

Dr. Trimble's greatest ability was along the line in which he had the greatest experience, that of emergency surgery, and he was looked upon as the best equipped man for dealing with emergencies, large or small. He had marked ability as an organizer, and the reorganization of the medical department of the Baltimore & Ohio Railroad was largely due to his ability and foresight. He was not content to conduct the organization from a distance, but made numerous trips over the entire Baltimore & Ohio system, and knew personally practically all of the surgeons employed by the road, and gave his personal attention to the selection of the men who were to fill these important positions.

As a teacher he was the embodiment of the practical, and one who was loved and respected by the students from the outset. He was one of the most popular medical men in the city, and had a very large acquaintance with the profession, not only in Baltimore, but throughout the State. He did a very large consulting practice, both in Baltimore and in the surrounding territory. He was a man of remarkable energy, being able to accomplish more work in twenty-four hours, and keep it up day in and day out, than almost any one that the writer has ever known.

Socially he was a man of great charm, and before his practice became so large as to occupy all of his time, he took a very prominent part in the social life of the city. He was a member, and for several years one of the governors, of the Baltimore Club, a member of the Maryland Club, a member and one of the governors of the Junior Cotillion Club, and a member of the Bachelor Cotillion Club. He had a peculiar genius for friendship and probably had more close friends than any other man in the city. He was familiarly known to all of these as "Ridge" Trimble. He kept open house, and his home was the gathering place of his many friends, who were always sure to find a warm welcome, and typical Eastern Shore hospitality.

His home on West Madison Street is one of the most attractive houses in the city. Filled with antique furniture, most of which he had inherited, but some of which he had collected himself. He had a very expert knowledge of the value of furniture of the colonial period. In 1897 he was married to Miss Margaret Jones, of New York, and she and his five children survive him.

The funeral services were conducted at Memorial Church, of which he was a member and one of the vestrymen, by the Reverend Mr. Dame. The interment was in the old family burying ground of the Lloyds, at Wye House, near Easton, Maryland, the funeral party having been taken there on a special train by the Pennsylvania Railroad.

In closing, perhaps no better tribute could be found than a letter written to the *Baltimore News* and signed W. S., which is quoted below in full:

While the attendance at Dr. Trimble's funeral bore unmistakable testimony to the deservedly high esteem in which he was held by this community, as a unit among the many I feel moved to echo aloud the eloquent tribute to his memory. So various are the "morals" to which his life and death point that it would require more space to record than I could ask of you. But there are certain pertinent lessons which none of us, I think, can afford to miss, and which it behooves us all to lay fast hold upon lest their significance escape us in our hour of need or fail us in the crucial test. Such men as were Dr. Trimble never really die. The good that they do lives after them, and the seed which they sow must somewhere, somehow, sooner or later, fall upon good ground where they shall be quickened even as he is now. Let us see to it that none of these seeds be lost in this city, where he labored and spent himself so abundantly, and where his shining example is as a beacon light to those who would follow rightly in the footprints he has so truly left behind him in the sands of time. To all young men with a future before them such an example is of priceless worth; whether they belong to his profession or another, to all alike has he left a legacy of enduring value. Older men, as well as contemporaries, who knew his sterling qualities and valued his character no less than skill, mourn his loss as infinite, if not, indeed, irreparable. To some one's lot it must fall to take up the work where he has laid it down; perhaps more than one will share in the task, and to these I would say the greatest honor they can offer his memory, with becoming credit to themselves, will be to do even as he would have done. A useful, valuable life is ended here after a brave fight upon his part and untiring devotion upon the part of his brother-doctors. In the prime of manhood, at the zenith of his profession, he has gone to join "the choir invisible," where the spirit of one more just man shall be made perfect. Therefore, we sorrow not for him, but rather for ourselves—for the loss inestimable to so many. But chiefly for those nearest and dearest to him, who shall know him no more "until God's love set them at his side again." To these I proffer my deepest sympathy, invoking for

them "the benediction which follows after prayer," as I reverently lay my sprig of rosemary upon his grave, where to-day we leave him, with the comforting assurance in a certain faith that he now rests from his labors and in perfect peace.

THE RELATION OF MILK TO DISEASE.

By DR. JOHN RUHRÄH, '96.

As you are doubtless aware, this course of lectures has been arranged by the State Medical Society, the Medical and Chirurgical Faculty of Maryland, for the purpose of giving to the public the facts in connection with preventable diseases, with the hope of lessening the amount of needless suffering and lowering our unnecessarily high death rate. Lord Derby, who has always been very much interested in sanitation and hygiene, once said, that sanitary education was more needed than sanitary legislation. It matters not how good the laws if the people will not live up to them of their own accord; it will not avail much in the prevention of disease. These lectures are part of a great educational movement that is being carried on in various parts of the country. This movement concerns certain problems that have to do with the prevention of disease. There are some diseases which are preventable, and of these, there are certain ones which we know how to prevent. The number of cases of the various infectious diseases, as tuberculosis, typhoid fever, cholera, and the like, can be prevented when the interest of the public can be secured. There are other movements of just as great importance, and these are connected with our food supply and our water supply. There is one food which is used practically by everybody, and especially by the very young, the very old, and the sick, which needs especial attention on account of its intimate relation to the production of various forms of disease; and it is to the consideration of the relation of milk to disease that I wish to call your attention this evening.

The importance of the subject can be made more impressive by the following figures: The amount of milk consumed in the United States is perhaps larger than that in any other country. According to the 12th census, there was sold in 1899, 740,000,000 gallons, excluding that used for butter, cheese, and condensed milk. This milk went to the non-farming population, and the average consumption was about 23 gallons to the person. In Philadelphia, in 1905, it was estimated that each

person consumed about 23 gallons of milk in a year, which was about double the amount estimated for the inhabitants of London. In 1905, the United States census had returns from the cause of death in a territory with a population of nearly 34,000,000 people. There were 545,533 deaths; of these, 105,533, or one-third of the entire number, occurred in infants under one year of age, and about one-third of these latter, or 39,399 to be exact, died of diarrhœa; and infantile diarrhœa, in almost every instance can be traced to spoiled milk.

The problem is a great one, and we can do no more than take up a few of the more important phases of it. We have to consider milk as a carrier of infectious diseases; milk as a source of disease because of poisons which have developed in it through improper care or handling, and milk as a source of disease from preservatives that have been added to it, and also the effects of adulterated milk.

The diseases may come from the cow or they may be introduced into the milk by the milkers or those who handle the milk, or the milk may become dangerous on account of the number of ordinary bacteria being present in excessive numbers. I wish to take up each one of these briefly, as each presents certain features of interest.

The diseases of the cow which may be transmitted in the milk and affect the consumer are, for the most part, not very common diseases. We need only mention two of them: The first is one about which there has been a great deal of discussion, and that is, tuberculosis. It is a very well-known fact that tuberculosis is a very common disease in cattle and that a great many milch cows have the disease. During the past two years, there has been a great deal of discussion as to the amount of danger there is in using milk from such cows. Anderson, who made studies of the Washington milk supply, found the tubercle bacillus in 6.72 per cent of all the samples examined, and found that 11 per cent of the dairies supplying the city were furnishing milk containing tubercle bacilli. Tubercle bacilli have been demonstrated in the dust from stables where tuberculous cattle are kept and this explains the high percentage. It is suggested that milk coming from such dairy farms should be pasteurized to safeguard the public from the disease. It is not pleasant to think of using milk given by a tuberculous cow as food, but the risk of transmitting tuberculosis from the cow to man is not very

great unless the cow has the disease in a very advanced form, or unless it is in the mammary gland or the udder. Even then, this risk is somewhat lessened, as milk is generally mixed with that of other cows before it is sold, and the tubercle bacillus does not multiply in the milk as do many other forms of bacteria. I believe the danger of contracting tuberculosis by the use of milk has been very much overestimated, and as far as the public is concerned, they can safely leave this part of the problem, for the present, to the consideration of the health authorities.

A second disease, and one which is really more common, is one of septic infection or blood poisoning. This is caused by a form of bacteria called the streptococcus, and this germ gets into the milk when the cow is suffering with certain diseases, or has sores upon the udder. In man it gives rise to a disease which may at times resemble scarlet fever, or at other times may be a cause of intestinal disturbance.

There are certain infectious diseases which affect man which may be carried in the milk as they might be carried in any other object. There are only two which need be mentioned, scarlet fever and diphtheria; and epidemics of both of these have occasionally been traced to milk. The usual way for a person to get either one of these diseases, is by coming in contact with some one who has, or recently had the disease, or by coming in contact with some object that has been used by a person ill with the disease. The way in which they are carried in milk is very simple. Some one who handles the milk has the disease and the germs get into it from them, or sometimes members of their family are affected and the worker carries it on his hands and thus gets it into the milk; or in other instances, milk cans or bottles are left at houses in which there is either scarlet fever or diphtheria, and these bottles or cans are used again without having been sufficiently cleansed.

As an example of an epidemic of scarlet fever caused by milk, one which occurred in Rochester, New York, March, 1905, may be cited. The cases of scarlet fever occurred almost simultaneously in 25 families, widely scattered and people having no social intercourse. Other means of contagion could be eliminated. The only thing in common was that most of the 25 families took milk produced on a farm where a woman, convalescing from scarlet fever, had returned to milking the latter part of February. In addition, her children had just had scarlet fever, and the

milkman supplied milk to about 80 families. Kober tabulated 99 epidemics of scarlet fever and found that the cause of them was as follows: The disease at the dairy or milk farm, 68; persons employed at the dairy either lodged in or had visited infected houses, 6; from infected bottles or cans left in infected houses, 2; employees working while recovering or suffering from the disease, 17; employees acting as nurses, 10; milk stored in or near sick rooms, 3; infected cloth used in wiping cans, 1. In 19 instances the disease was attributed to disease of the udder, or to fever in the cow following the birth of a calf, and in these latter instances the disease was due to the streptococcus infection which, as I have already said, may at times resemble scarlet fever.

The disease which is to be feared more than any other, except the intestinal diseases, is typhoid fever. A great deal of stress should be laid on the investigation of milk as a source of outbreaks of this disease. An epidemic of typhoid fever usually means that the water supply, or that some part of the milk supply, has in some way become infected. Of course, the disease may be acquired in other ways, directly from the typhoid fever patient, or it may be carried by flies. The first point of interest is how the typhoid fever bacillus gets into the milk, and this question may be answered in a few words by again quoting Kober, who investigated 195 epidemics in which milk was the cause of the disease. In 67 instances the milk was infected by using water from a well that was contaminated by the typhoid fever bacillus, and in 16 of these, the water had been used to dilute the milk. In seven instances, the disease was attributed to the cows wading in infected sewage, or in polluted streams or pastures. In 24 instances, the dairy employees acted as nurses, and in 10, patients suffering from mild attacks of typhoid fever continued at work. In one instance, the milk cans were washed with a dish cloth used among fever patients, and in two instances, the dairy employees were connected with the night-soil service, and in two other instances, the milk had been kept in the sick room. The infection may occur at the dairy farm, when one considers that the number of persons living at the dairy farm averages about seven, and also the fact that every year in the United States one person in every 300 has typhoid fever. A city which obtains its milk supply from, say, 1000 dairy farms, as Washington does for example, some 25 cases of typhoid fever might be expected to occur at the sources

of milk supply each year. In many instances, the disease is mild and may pass unrecognized, or the patients may even continue at work for a certain part of the time during their illness. Flies may pass from infected excreta to the milk, or milk cans, and so readily convey the infection. At the dairy the milk is again exposed, and the cans or bottles return from houses, in which there are typhoid patients, where they have been handled by persons caring for the sick, and not disinfected before use, may be the means of disseminating the disease. In the small grocery shops the danger of infection is particularly great, should a case of typhoid fever occur in the family of the shop-keeper, and considering the great frequency of typhoid fever, this happens very often. And then the milk may be infected at the home by the hands of those caring for the sick, or by flies, and so the infection carried to the healthy members of the family. The typhoid bacillus increases rapidly in milk, so that a very few bacteria getting into the milk, may, in a few hours, become a very large number.

As an example of a milk-spread epidemic, one which occurred in Baltimore in 1903 may be related. Twenty-six cases of typhoid fever developed in rapid succession amongst the employees of one factory. The factory served dairy lunch, the milk of which came from a farm where the water supply was found polluted.

The disease which is to be feared more than any other from milk, is diarrhœa, and the greatest danger is in young infants. Out of the 10,000 who die in Baltimore every year, 3000, or approximately one-third of the whole number, are under five years of age, and more than 2000 have not completed their first year. Fully 1000 children die in Baltimore every year, the cause of death being directly or indirectly due to improper food, lack of care, and lack of fresh air. Every summer an epidemic of diarrhœa kills about 500 babies, and a very large number of others are rendered ill for a few days, a few weeks, or even for months and years by the same scourge. It is not necessary to dwell upon these facts. The chief cause of the diarrhœal diseases is spoiled milk. The diarrhœa is caused in several ways: In the first place, the milk may become infected with bacteria which produce diarrhœa. There is no specific diarrhœa germ, but a number of different ones may be the cause. Sometimes the dysentery bacillus, sometimes the streptococcus, sometimes others.

These bacteria are not normally in milk, but must have come from some patient suffering with the disease, or other recognized sources. There are normally present in the milk a large number of bacteria, which under ordinary circumstances are harmless, but they may increase to such a number that the milk is really nothing more than a culture of bacteria. If the milk were transparent, they occur in such numbers that they would be visible to the naked eye; but on account of the opacity of the milk, they may exist without being detected, unless special investigation is made. For example, the purest milk contains 5000 or less bacteria to the cubic centimeter, and average milk from this number up to about 50,000. Specimens of market milk from various places have been found to contain many more. In Washington, in the summer of 1906, specimens of the milk were examined by the Public Health and Marine Hospital Service, which showed a maximum of 307,800,000 bacteria to the cubic centimeter, or approximately 1,228,000,000 to the teaspoonful. Such an enormous number of bacteria in the milk may be the cause of diarrhoea when the bacteria are those which normally are found in the milk. Some of the bacteria, however, may produce poisons or toxins, and these poisons may also cause diarrhoea, so that in bad milk that is sterilized, or has preservatives added to it to kill the bacteria, the toxins remain and the milk may be the cause of disease. The milk which is sold in the small grocery shops from an open can, is almost always the most dangerous thing to feed a baby, either in summer or winter, but especially in summer. I have seen many cases of summer diarrhoea caused by one feeding of grocery-store milk; the home supply having run short or the milk wagon being late, and an additional supply having been procured from the nearest grocery shop.

The question of the adulteration of milk is a serious one, but affects the pocket book of the public rather more than their health, as most of the adulteration, nowadays, cannot be said to be of an especially dangerous character. The commonest form of adulteration is skimming the milk, or what amounts to the same thing, adding skimmed milk to whole milk. The next commonest thing, is to dilute the milk with water. Unfortunately, in a considerable number of instances the water that had been added had been polluted with disease germs. Both skimming and adding water render it a less valuable food, and in the case of feeding of infants

or of invalids the difference in the composition of the milk may be a matter of considerable importance. I have seen in a number of instances, infants who were not thriving on certain milk mixtures, pick up immediately without changing the formula, but on changing the supply of milk from a poor one to a good one.

Substances are sometimes put in the milk to thicken it. This is perhaps not as common as formerly. Coloring matter is frequently added, the chief of these being annatto, which gives the milk a yellow color; caramel is also used, and sometimes other dyes. The use of coloring matters in milk should be prohibited by law because it is an attempt to deceive the public as to the quality of the product sold. Substances are occasionally added to the milk to alter its taste, chiefly to conceal that the milk is sour or just turning. Sodium carbonate or bicarbonate are frequently added for this purpose; sometimes sugar, or sometimes saccharine.

The use of preservatives is another serious thing. There has been a great deal of discussion on this subject, and a great number of experiments have been made, the results of which have not been entirely in accord. It may be very safely stated, however, that the use of any preservative in milk is objectionable and should be prohibited by law. There are two principal reasons for this. In the first place, almost all preservatives, if not all, are injurious to health, even in small amounts, if continued over any period of time; and they are particularly injurious to the two classes of people who make the most use of milk, that is, infants and invalids. The second reason is that whilst the use of preservatives delays the souring of milk, unless used in comparatively large quantities it has but little effect upon the multiplication of many disease germs, as typhoid for example, and it has no effect upon the toxins or poisons that may have already developed before the preservative is added; so that the milk, whilst tasting sweet, may still be laden with disease-producing bacteria, or contain large amounts of bacterial poisons. In other words, the use of preservatives removes the danger signal without removing the danger.

A great many different chemicals have been used in milk, the most important of which are, formaldehyde, boric acid, borax, salicylic acid, and benzoic acid. It has been quite definitely shown that all of these are injurious, and some of them very dangerous, and their use should be prohibited by law, and dealers selling or distributing milk containing pre-

servatives should be fined and the fact published in the daily papers, as a warning to others. Milk containing preservatives is usually spoiled when the preservatives are added, as they are most likely to be added by unscrupulous dealers who find it easier to embalm the milk than to keep it cool and handle it carefully; and the consumer who has an idea that milk is good unless it sours, often uses this milk, but with most unfortunate results. I remember on one instance seeing an infant that had been made ill by milk, and on asking the mother about the quality of milk used, she remarked that she got the very best milk possible; it was so much better than ordinary milk as it would keep as long as she wanted, that sometimes she had it standing in the kitchen for a week without its turning sour. On investigation, it was found that the milk had formaldehyde in it.

The question of how to avoid disease from milk is one of great practical interest, and may be answered in a few words: Cleanliness; keep the milk cold; and rapid transportation from the cow to the consumer. These means of preventing disease can only be put in force by the education and the co-operation of the dairymen, health authorities, and the public. The methods of producing milk and caring for it are well known. The cows should be healthy and well cared for and the stables should be clean, as free from dust as possible, and thoroughly ventilated. The hands of the milkers should be sterilized, and the milk cans, pails, and bottles, which are used to hold the milk, should be thoroughly cleansed and sterilized. The water supply about the dairy should be free from pollution. One of the most important factors in keeping milk is to have it cooled immediately after its milking, and to have it kept cool until its use, as this prevents the multiplication of bacteria; and milk which is produced on a clean dairy farm, kept clean, and kept cold, should keep 24 hours or more without any difficulty. The milk should be safeguarded during transportation and the same care taken of it at the distributing dairy. There should be supervision over dairy farms, distributing dairies, and milk wagons.

A very good ordinance has been introduced in the Baltimore City Council for the purpose of regulating the production and sale of milk in Baltimore City. It provides that only pure, unadulterated, unsophisticated, and wholesome milk shall be sold or offered for sale, and that such

article shall be the natural product of healthy cows, and which has not been deprived of any part of its cream, and to which no additional liquid, solid or preservative, has been added, and which, at a temperature of 60° Fahrenheit, shall have its specific gravity of not less than 1.029, not less than 12½ per cent of total solids, and not less than 3½ per cent of butter fats. It permits, however, the sale of skimmed milk, of butter milk or modified milk, under the prescription of a physician, provided they are sold as such, and that the purchaser be in every instance notified of their true character. In order that the health officer know the name and address of every one dealing in milk, the ordinance provides for the licensing of all such people, and its permits may be revoked by the commissioner of health for persistent, repeated, or willful violation of any law or ordinance governing the sale of milk. The commissioner of health is given power to adopt such regulations as he may deem necessary to insure all milk and cream intended for consumption in Baltimore City being produced, transported, stored, kept, distributed, retailed, and delivered under conditions rendering them suitable as human food, and to compel perfect hygienic and perfect sanitary conditions of cow stables, creameries, and dairies from which milk and cream so intended for consumption in Baltimore City are produced. The ordinance also provides for the cleansing and sterilizing of the milk cans, bottles, and other receptacles and containers before milk or cream is placed in them. It also makes it unlawful for any person in the milk business to have on the premises or in any milk wagon, any drugs or chemicals to be used in coloring, adulterating, sophisticating, or preserving milk or cream. The ordinance further provides for the inspection and examination of milk by the health authorities. If it passes, the ordinance should do a great deal towards improving the milk supply of the city.

Various suggestions have been made with a view of furnishing the consumer with some idea of the kinds of milk he is getting, and of lessening the danger from using the milk.

The best milk is known as certified milk, which is guaranteed by a milk commission. Such milk is produced under the most hygienic conditions, the production and distribution being carefully supervised, and bacteriologic and chemic tests being frequently made by experts in the employ of the commission, which certifies as to the purity of the milk.

There are milk commissions in a great many of our large cities, and the dairyman producing and distributing certified milk is under bond to furnish milk of a certain standard of purity. The milk bottles are sealed and bear the stamp of the commission's officer.

A second grade of milk might be called inspected milk. Such milk is that which has been produced at farms and handled at dairies which are under supervision, but the producers and distributors are not under bond, nor is the milk guaranteed to be of any definite standard. Milk which is neither certified nor inspected may or may not be reasonably pure.

It has been suggested that during the summer it would be a good idea to have the milk supplied to cities, which is neither certified nor inspected, put through some process to render it less liable to produce disease. The only method that could be recommended, for this, is what is known as pasteurizing. This is heating the milk at a sufficiently high temperature to kill off the majority of the bacteria present, but not high enough or long enough to change the composition of the milk. This has been done in some cities with tolerable success in reducing the infant mortality from diarrhoeal diseases.

The ideal to be aimed at, however, is milk which will keep and be free from danger without having anything done to it; and we know that such milk can be produced without a great deal of difficulty.

Lastly, a great factor in reducing infant mortality from spoiled milk, is to have depots where pure milk is supplied to the poor for their babies. This work has been carried on in many of the cities with remarkably good results, and we have in Baltimore a Babies' Milk Fund, which every year has been spent in distributing milk to a number of families, at a nominal price, and has been the means of saving a great many lives and preventing a great deal of suffering. It is a particularly worthy charity and one which deserves the support of the public. It not only relieves suffering, but it educates the people to the necessity of pure milk.

DIAGNOSTIC POINTS IN TUBERCULOUS MENINGITIS, WITH A REPORT OF FOUR CASES.

By DR. M. D. COHEN, '04.

The signs and symptoms of meningitis are so well known that I shall not go into them, except in so far as the differential points are concerned.

Neither is it my intention to go into details on the subject of differential diagnosis of the various forms of meningitis; but rather to elucidate as briefly as possible the characteristic points whereby the tuberculous form of the disease may be recognized.

The average physician can diagnose meningitis almost at a glance by the rigidity of the muscles of the neck, the retraction of the head, Kernig's sign, the condition of the eyes, etc., but to make the diagnosis of the tuberculous form with the assurance that you are not mistaken is often another matter. It is necessary to make a careful physical examination in addition to the history obtained, which should be clear in itself. This having been done the diagnosis is nearly made. Other forms of meningitis may be excluded by the history alone. I believe it was Osler who said: "If the diagnosis is tuberculous meningitis and the patient dies, the chances are that you are right, but if the patient recovers you are wrong." This may be true to a certain extent, since we know that the majority of the patients die; yet there is no doubt that a percentage (however small it may be) of the cases do recover, though usually with some stigma, as in the other forms of meningitis, such as partial deafness, or blindness, or both, or idiocy. Baldwin says: "The number of recoveries are few and exceptional." I have been unable to find the percentage of recoveries in the literature I have at hand. I have seen four cases in the past few years with a mortality of 50 per cent. Of these, however, we will speak later.

The ordinary signs of meningitis, as I stated above, are easily recognized; but how are we to differentiate the tuberculous form of the disease? The signs and symptoms of this form may be taken by themselves and then compared with the signs and symptoms of the other forms of meningitis.

It is an indisputable fact, I think, that in tuberculous meningitis the onset is always slow, so slow, in fact, as to make it a sign of great value from a diagnostic point of view. It is usually a matter of weeks, even months, before the physician is called in. In a series of cases, observed by Koplik, 86 per cent of the series had a slow onset. The onset consists of headache, more or less severe, interrupted by periods of reasonable comfort. Then, after a period varying from a week to a month or more, there may be a convulsion, followed by unconsciousness, and the

usual signs of meningitis. The retraction of the head comes on later in this form of the disease and may be absent altogether. The condition of the eyes presents nothing materially different from any other form of meningitis, though it has been observed that the degree of strabismus is not so great and is often entirely absent. Kernig's sign is present in from 80 per cent to 90 per cent of the cases, while it was present in 95 per cent of a series of 208 cases of epidemic cerebrospinal meningitis observed by Kernig, and 93 per cent of the 248 cases reported by Koplik during the past year. Koplik, however, lays special stress on Babinski's reflex as a diagnostic sign in tuberculous meningitis. He says: "This sign by itself in a suspected case is diagnostic." It was positive in 24 of 26 cases. Baldwin mentions the significance of the presence of tuberculosis in some other part of the body. At any rate, in a case of meningitis, where a history of tuberculosis is obtained, or a tubercular lesion found on examination, one is justified in making a diagnosis of tuberculous meningitis. Most authorities claim that a primary lesion can be found in every case; though often only on the post-mortem table.

The first glance at a patient suffering from tuberculous meningitis during the period of unconsciousness, presents such a picture as to make the physician think of a compressed fracture of the skull. I know of no other disease or injury that presents this same picture. The dilated pupils, stertorous respiration, and the slow, full pulse, as well as the flushed face, etc., are signs suspicious of only two diseases; viz, compression of the brain and tuberculous meningitis.

The temperature during the onset is usually subnormal, but after the patient becomes unconscious it rises rapidly to 104° - 106° , or even higher. If at this time lumbar puncture be made and the fluid be centrifugalized, the bacillus of tuberculosis can be demonstrated by the ordinary laboratory methods. To recapitulate, I desire to call your attention particularly to the following signs and symptoms diagnostic of tuberculous meningitis:

- A. The presence of a tubercular lesion in some other part of the body.
- B. The history of the case, characterized by intense headaches, interrupted by periods of reasonable comfort.
- C. A positive Babinski reflex. This reflex being present in at least

95 per cent of the cases as against 16 per cent to 20 per cent of the cases of epidemic meningitis.

D. Retraction of the head and rigidity of muscles of the neck not marked early in the disease, and often absent.

E. Stertorous respiration, often Cheyne-Stokes in character. The respiration in the epidemic form of the disease is always shallow and rarely of the Cheyne-Stokes' type.

F. The pulse during the period of onset is rapid, small, and irregular; but after unconsciousness it becomes slow, full, and bounding.

G. General condition resembling depressed fracture of the skull.

H. Temperature is usually subnormal during the onset, but rises rapidly later and may reach 106° or 108° , or even higher. Prof. Jacobi reported a case for which he had to have a special thermometer made, so high was the temperature.

I. By making lumbar puncture and centrifugalizing the fluid the organism of tuberculosis can be demonstrated.

Report of four cases of tuberculous meningitis:

CASE I.—Male, æt. four years. Had never been sick. Had been suffering for three weeks with periodical attacks of headache and general irritability. He was taken suddenly with a convulsion and a physician was called in for the first time, after which he was seen by at least ten doctors in the following two days. The diagnosis varied from meningitis to pneumonia and mumps. Finally on consultation it was agreed that the signs pointed to tuberculous meningitis and a fatal ending was prognosed. No tuberculosis was found on careful physical examination and there was no history of tuberculosis in the family. However, the history of the case, in addition to the positive Babinski reflex, led us to the firm belief that the diagnosis was correct. The child made a good recovery and is to-day absolutely normal in every way; two years after the disease. No lumbar puncture was done in this case and the diagnosis was really made on the slow onset, positive Babinski, absence of retraction of the head, and the general condition of the patient. I might add that Kernig's sign was positive.

CASE II.—Male, æt. 30; merchant by occupation. Usual diseases of childhood. Had been suffering for two months with intense headaches, interrupted by periods of reasonable comfort. He was taken suddenly with a convulsion, followed by unconsciousness characterized by loud outcries, retraction of the head, positive Kernig's sign and Babinski's reflex. On physical examination a tuberculous focus was found in the right apex. The diagnosis of tuberculous meningitis was made. Lumbar puncture was done and the bacillus of tuberculosis found, which verified the diagnosis. The patient died two days later and the diagnosis was again proved on the post-mortem table.

CASE III.—Male, æt. 13. Usual diseases of childhood. Had been suffering for two years with pulmonary tuberculosis. He had been complaining for five weeks with intense headache and irritability, interrupted by periods of reasonable comfort. He became unconscious suddenly without any other manifestation. Babinski's reflex and Kernig's sign positive, retraction of head not marked, stertorous respiration, and slow, full, and bounding pulse. Lumbar puncture showed positive results. After three weeks of unconsciousness, he gradually recovered, and is now in good condition physically, except that he is partially deaf and blind.

CASE IV.—Male, æt. about 35. Telegraph operator by occupation. Usual diseases of childhood. Had been suffering for the past few years with tuberculosis of the lungs, larynx, and nasal cavities. He came west with the hope that the change of climate and altitude would be of benefit to him. Had been suffering with intense headaches for a period extending over months, with the usual intermissions. He failed to appear for work one morning and his assistant, going to his room, found the door locked and heard loud outcries. He then called in the neighbors and the door was forced. The patient was found in a convulsion. He had several convulsions before I got there. I obtained the history as given above from his friends and neighbors.

On physical examination, tuberculosis of both lungs, also of the throat and nose. Babinski's reflex and Kernig's sign positive, retraction of the head marked, stertorous respiration, and slow, full, bounding pulse. He presented the usual appearance of compression, and was really a typical case. Lumbar puncture was not done. He continued to have convulsions at intervals of about half an hour. After continuing in this condition for thirty-six hours, died during a convulsion.

There was no autopsy, but there is little doubt as to what would have been found. There must have been extensive involvement of the meninges in this case.

ABDOMINAL PAIN.

By DR. WALTER D. WISE, '06.

Pain is an expression in consciousness of injury to the peripheral or central nervous system by irritation or a lesion. This definition does not include the hyperæsthesias, hyperalgesias or simulated pains. It may be caused by disease of the central nervous system, or the nerve trunks, by inflammations, by intoxicants, by pressure on nerve trunks, and by reflex influences. Pain is usually first learned of by the complaints of the patient, but simply from statements it is hard to tell how much an individual is suffering; fortunately there are other methods which are of value to the physician, as the (a) facial expression—a valuable description of an intense pain with a placid face means much less than a few words with clinched jaws, livid countenance, rapid respiration, and dilated pupils.

(b) Posture is frequently a valuable sign of pain, as the flexed thigh in peritonitis; the restlessness in intestinal colic; the dropped shoulder in renal colic. Of great diagnostic importance is the onset of pain, for example: its acuteness, in obstruction of the bowels, gall stones, ruptured viscera, etc.; its gradual onset, in chronic inflammation and tumors. The time of occurrence is important, whether diurnal or nocturnal; the former being commonly functional—the latter frequently syphilitic. A gastric pain before meals would point to gastralgia; after meals to ulcer or cancer. As to character, a cutting pain in the abdomen points to colic; throbbing pain to inflammation; dull pain to visceral disease.

The seat of pain ordinarily corresponds to the location of the lesion, but in many instances it is reflex, being at a far termination of a nerve, when the lesion is at a termination near the origin of the nerve, or irritation of one branch may cause pain in another branch supplying a different locality.

A transferred sensation is one perceived by the sensorium not as belonging to its real source of origin, but because of indirect sensory connections is referred to an entirely different portion of the periphery—as the pain in the breast due to uterine disease. The researches of Stead make it appear that when a stimulus is applied to an organ of a low degree of sensibility which is closely connected centrally with an organ of high sensibility, the pain is felt in the more sensitive organ; hence the tenderness of the skin in visceral disease.

It is the opinion of Lennander that all painful sensations within the abdominal cavity are transmitted only by means of the parietal peritoneum and its subserous layer, both of which are richly supplied with cerebrospinal nerves. These nerves, extending around the entire abdominal cavity with the exception of a small area below the crura of the diaphragm between the sympathetics, in which area there is no sense of pain on pressure, pricking, or stretching the attached mesentery.

Abdominal organs which are supplied by the vagus and sympathetic *only* have no sense of pain. Painful sensations within the abdomen are transmitted *only* by cerebrospinal nerves. These nerves are the phrenic—lower six intercostals—lumbar and sacral.

The liver, gall bladder, stomach and intestines are in addition to being free from painful sensation, free from sensibility to pressure, heat, and

cold. The intestine may be cut, pinched with forceps, or burned with the cautery, without the slightest pain, but the moment its mesentery is put upon the stretch, thereby affecting the parietal peritoneum, there is pain. Comparatively recently, Drs. Meltzer and Kast, of New York, tried to prove the visceral peritoneum to be sensitive, claiming that contrary results obtained by other experimenters were due to cocain used to anæsthetize the abdominal wall. This evidence was refuted in May, 1907, by Dr. J. F. Mitchell, of Washington, who did two laparotomies under saline anæsthesia with the same results that he had obtained with cocain. The idea that simple exposure of the visceral peritoneum to the air might produce anæsthesia has been pretty well disproved by Dr. Beer, who reached his conclusions by working upon herniæ and through the hernial canal.

The parietal peritoneum is said to be insensitive to heat, cold, and pressure, thus giving another illustration of special nerves of pain. A condition formerly known to exist only in the cornea.

Some causes of pain in the abdomen at the location of the pain-producing lesion are the following:

Right Hypochondriac Region.—Gall stones, cholecystitis, empyema of the gall bladder, passive congestion of the liver, suppurative, hydatid or syphilitic disease, cancer, cirrhosis, subphrenic abscess, impacted colon, cancer of stomach, pyloric or duodenal peritonitis, pyelitis, uræmia, rheumatism.

Epigastric Region.—Gastritis, ulcer of stomach, cancer of stomach, gastrectasis, gastralgia, hyperchlorhydria, Parsons, appendicitis, ulcer of duodenum, enteropleasis, impacted colon, hepateasis, pancreatic disease.

Left Hypochondrium.—Impacted colon, colitis, gastritis, carcinoma or ulcer of stomach, dilated stomach, enlarged spleen, peripleuritis, infarction of spleen, movable kidney, renal colic, pyelitis.

Lumbar Regions.—Lumbago, debility, flatulence, appendicitis, hernia, dysmenorrhœa, movable kidney, kidney tumor, renal calculus, hydro- or pyonephrosis, pyelonephritis, lumbar abscess, acute nephritis, prostatitis, febrile infections.

Right Iliac.—Appendicitis, impacted cæcum, typhoid fever, colitis, hernia or patulous internal ring, varicocele, ovaritis, salpingitis, ectopic gestation, prolapsed ovary.

Left Iliac Region.—Colitis, impacted sigmoid, hernia, varicocele, valvulus, salpingitis, ectopic gestation, prolapsed ovary.

Hypogastric Region.—Cystitis, pyelitis, ulcer, tuberculosis or cancer of bladder, vesical calculus, various uterine and ovarian diseases, pelvic inflammations, intermenstrual pain, normal pregnancy.

These long lists of possible conditions are mentioned because no matter how clearly defined symptoms and signs may be, if the diseases that may exist are not known a diagnosis can not be made.

A few fairly constant points of pain in intestinal disease are McBurney's point in appendicitis, a point mid-way between the crest of the ilium and the umbilicus or the right side in intussusception. A point corresponding to McBurney's point on the left side in valvulus.

Some causes of pain more or less general are: Arsenical, mercurial, or lead poisoning, flatulence, tubercular peritonitis, angina pectoris, embolism of superior mesenteric artery, hysteria, trichiniasis, herniæ.

Transferred pain to the abdomen may be due to pneumonia, pleurisy, empyema, asthma, valvular disease of the heart, aneurism of the aorta, Potts disease or other disease of the vertebral, tabes dorsalis, myelitis, spondylitis, pericarditis, orchitis.

Pain transferred from the abdomen is seen in uterine disturbances giving pain in the breasts. Precordial pain in gastric disease, pain in the clavicular region due to diaphragm or colon disease, pain in the upper part of the thigh in ovarian disease, pain in the heel in disease of the prostate.

THE TRIMBLE LECTURESHIP.

There is a general feeling among the friends of the late Dr. Isaac Ridgeway Trimble that there should be in Baltimore some suitable memorial of this remarkable man, whose beneficent influence was so widely felt.

There could be no more fitting monument to his memory than the foundation of a permanent lectureship which should provide for the delivery, at stated intervals, of one or more lectures by distinguished investigators or practitioners in the field of medical science or art.

It has accordingly been suggested that a fund be established for the endowment of such a lectureship. This endowment should be sufficient

to yield a sum which would make it possible to invite, as lecturers, men of distinction from all parts of the world. It is desirable that the lecture should be delivered annually, biennially, or triennially.

When the sum reaches a sufficient size, it is proposed to offer it to the Medical and Chirurgical Faculty of Maryland for the purpose of founding a permanent lectureship, to be called the "Trimble Lectureship," with the request that the Trimble Lecture or Lectures be delivered in Baltimore before the Faculty at its annual meeting or at some other time to be agreed upon. In this manner the name of this noble man, who exemplified, as few have, that which was highest and purest and best in life, will be forever associated with the progress of the art which he so dearly loved.

It is believed that there are in this community many who will gladly welcome the opportunity to join in contributing to such a memorial, and all contributions, however small, will be welcome. It would have been peculiarly gratifying to him to know that such a memorial were to come, not from a few large solicited contributions, but from the small and voluntary gifts of those, who owe their lives, their happiness, or their success to his skill and inspiration.

Subscriptions to the endowment fund of the Trimble Lectureship may be sent to Messrs. Alexander Brown & Sons, Baltimore and Calvert Streets.

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

COMMENCEMENT ANNOUNCEMENT.

The annual meeting of the Alumni Association will be held at the college Tuesday, June 2, at 8.30 p. m.

The commencement will be at Albaugh's Theater, North Charles Street, Wednesday, June 3, at 8 p. m.

The annual dinner of the Alumni Association will follow immediately after the commencement exercises.

REUNION CLASS OF '79.

THE class of '79 has practically completed its program for the class reunion to be held at the commencement of the College of Physicians and Surgeons. On Monday, June 1, at night, a class banquet at Hotel Junker, 20 E. Fayette St. Tuesday night, June 2, Alumni meeting at the College building; Annual Address by the president of the class of '79, Dr. Lewis A. Griffith. Wednesday night, June 3, Commencement and Annual Banquet. Accommodations can be obtained for the visiting Alumni at Junker's Hotel at moderate rates.

Information is desired regarding the following members: Judson H. Booker, Virginia; George Fischer, Germany; B. A. Guyton, Maryland; Napoleon B. Kinker, Maryland; J. T. Martin, Virginia; J. F. White, Indiana.

Any information concerning missing members of our class—living or dead—will be highly appreciated by Geo. H. P. Cole, Roanoke, Va.

THE ALUMNI REUNION IN CHICAGO.

It has been suggested that the Alumni hold a reunion Tuesday evening, June 2, at the meeting of the American Medical Association to be held in Chicago from June 2 to June 5. This meeting will be held at some hotel, the exact location to be announced later in the journal of the American Medical Association. The general Alumni headquarters will be at the Auditorium, which will also be the general headquarters for the American Medical Association meeting.

Dr. Philip S. Chancellor, 577 N. State St., Chicago, is chairman of the Alumni Committee and will be willing to make reservations at hotels and boarding places for visiting Alumni. Requests for reservations and other information may be sent direct to him.

The officers of the Alumni Association of the College urge that all the Alumni contemplating going to Chicago notify Dr. Chancellor as soon as possible so that a satisfactory program and arrangements may be made.

CANCER OF THE UTERUS.

About 70 per cent of all cases of cancer of the uterus that are sent to the hospitals of this country for treatment have progressed so far that it is impossible to remove the growth. This deplorable state of affairs is due to the failure to recognize the disease at a time when it is more amenable to treatment. The failure to recognize the disease in its early stages is largely on account of the fact that the patients have not been educated to observe the danger signal that is usually present, and largely on account of the attending physicians beginning treatment without attempting to make a diagnosis. Hemorrhage from the uterus is a symptom indicating that there is something wrong. It is not a matter to be passed over lightly, and it is not a condition to be treated by the administration of drugs that have been represented by the seductive detail man as just the thing to relieve all the ills of womankind.

First determine the cause of the bleeding and then proceed with the treatment. The administration of drugs for the relief of uterine hemorrhage, without knowing what the cause, borders upon the criminal.

Obituary.

DR. Z. ELLIS KIMBLE, '86, died at his home in Asheville, N. C. April 14, 1907, aged 46.

DR. JOHN D. SCOTT, '68, of Roanoke, Va., was found dead in his office in that city, January 4, 1908, aged 79.

DR. VINCENT E. RADER, '92, died at his home in Pittsburg, Pa., March 4, 1908, after an operation for appendicitis, aged 42.

DR. CHARLES E. OATIS, JR., '79, died at his home in Hazelhurst, Miss., October 8, 1907, from nephritis, after a long illness, aged 49.

DR. HARVEY MILLER, '04, of Shinnston, W. Va., died at Cook Hospital, Fairmont, W. Va., February 10, 1908, from typhoid fever, aged 29.

DR. ARTHUR J. VARNO, '92, formerly a practitioner of New York City, died at the home of his father in Thompsonville, Conn., March 10, 1908, after an illness of four months, aged 36.

DR. FRANK P. WEBSTER, '78, Hahnemann Medical College and Hospital, Philadelphia, 1879, died suddenly from heart disease, April 26, 1907, at his home in Norfolk, Va., aged 54.

DR. MELVIN B. HUBBS, '83, formerly president of the Steuben County (N. Y.) Medical Society and president of the village of Addison, died at his home in that place, April 24, 1907, aged 55.

DR. FREDERICK F. NINDE, '84, a member of the Medical Society of Virginia and Westmoreland County Medical Society, died at his home in Colonial Beach, Va., March 10, 1908, from cerebral hemorrhage.

DR. SILAS K. COLEMAN, '82, a member of the Mississippi State Medical Association and Madison County Medical Society, died at his home in Canton, January 15, 1908, from heart disease, after an illness of several months, aged 58.

DR. JOHN MILTON WALLS, '96, a member of the State Medical Association of Texas and Morris County Medical Society, died at his home in Naples, Texas, January 25, 1908, from tuberculosis, after an illness of three months, aged 32.

DR. Z. W. WYATT, '84, a member of the West Virginia State Medical Association and Harrison County Medical Society; a member of the legislature in 1900 and 1901; died at his home in Shinnston, W. Va., January 31, 1908, after an illness of several weeks, aged 61.

DR. JOHN HENRY SCARFF, '76, at one time professor of gynecology in Baltimore Medical College, and one of the founders of the Hospital for the Women of Maryland, died at his home in Govanstown, Md., March 11, 1908, from nephritis, after an illness of several weeks, aged 57.

DR. HENRY JAMES HEBB, '73, a member of the Medico-Chirurgical Faculty of Maryland and Baltimore County Medical Society; a Confederate veteran, and at one time county treasurer and register of wills, died at his home in Randallstown, January 10, 1908, from paralysis, aged 65.

DR. TRIMBLE'S DEATH.

It is with great regret that we announce the death of Dr. Isaac Ridgeway Trimble, the professor of anatomy and clinical surgery. A short account of Dr. Trimble's illness will be found in the obituary notice at another place in this number.

In Dr. Trimble's death the College has lost one of the ablest members of the Faculty, and one it will be difficult to replace. The students of the College decided to have a portrait painted and hung in the College Library, and a number of his friends have sent out notices asking for subscriptions to a fund to be used as an endowment for a lectureship to be known as the "Trimble Lectureship." This fund is to be turned over to the Medical and Chirurgical Faculty of Maryland as soon as it reaches a sufficient size, to insure lectures either annually, biennially, or triennially. Notice of this lectureship will be found in another place in this issue of the JOURNAL.

Marriages.

DR. EDGAR F. FRIEDENWALD was married Monday, March 23, to Miss BETTY FREUNDLICH, of Charleston, W. Va.

DR. C. W. G. ROHRER was married to Miss EMMA MARIE ALBRECHT January 29. Dr. Rohrer, in addition to his connection with the College, is Medical Assistant to the State Board of Health of Maryland.

Personal Notes.

DR. PHILIP S. CHANCELLOR is located in Chicago and is devoting himself to diseases of children. He has been appointed Pediatrician to St. Joseph's Hospital.

DR. BRACK, business manager, requests that any of the Alumni having either college catalogues or announcements for sessions of '82-'83, '84-'85, '88-'89, '02-'03 would send copies of same to him.

DR. DONN C. HUGHES is Assistant Surgeon of the Gynecological Staff of the Home and Hospital of Findley, Ohio. The Home and Hospital is under the control of the City Board of Service, and is managed by a board of ladies. From the report we would judge that they are doing a large gynecological practice, and from illustrations that the hospital is one of the best in northern Ohio.

DR. WILLIAM BURN, '91, Addison, New York, has been elected president of the village. This office he has held before, and the particular note is that this time he was re-elected on a fusion ticket of Democrats and Republicans, both parties considering him the best man for the position. He is a member of the Steuben County and of the New York State Medical Societies, surgeon to the Buffalo & Susquehanna Railroad, and a good example of a physician going into politics and making a success of it.

Correspondence.

WASHINGTON, D. C., Feb. 6, 1908.

Dear Doctor Brack.—It becomes my painful duty to report the death of our chum and fellow graduate of the class of 1896, Dr. J. M. Walls, late of Naples, Texas. Dr. Walls was attending to a very large and lucrative practice until the early days of October last, when his health began to fail, and an examination disclosed the fact that he was a victim of the dreaded pulmonary tuberculosis.

He went to a sanatorium in his native State, but the progress of the disease could not be stayed, and he returned to his home in Naples, where he died on January 25, 1908. He was aged about 33 years, and leaves a widow and two children to mourn his loss. He was known to the boys of '96 as "Texas," and was one of the most popular men in the class.

After graduating he located in his native town, and in a remarkably short time he had built up a large practice, and soon became one of the leading practitioners in that section of his State.

DR. J. S. ARNOLD, '96.

YOUNGSTOWN, OHIO, March 1, 1908.

Dear Doctor Brack.—Just a few lines to let you know where we are. I opened an office here just a month ago, and prospects are bright. This is a hustling city of sixty-five thousand, with many industries and mills, of which the Carnegie and United Steel companies are the most important.

It was with much regret that I learned of the death of our beloved Doctor Trimble, whose many kindnesses and words of cheer, given us during college and hospital life, shall never be forgotten. A man among men, and one whom it was an honor to have known.

In closing, will say that I would be pleased to have you send me the JOURNAL as per inclosure.

With regards to yourself and all the others, I remain,

Yours sincerely,

H. H. THEIS.

SAN FRANCISCO, Nov. 22, 1907.

Dear Doctor Brack.—Please have the ALUMNI JOURNAL sent to me at 401 Fillmore St., San Francisco, Cal.

I have been here two months on special temporary duty in connection with the suppression of Bubonic Plague.

I hope to get to Baltimore next spring, about the time of the Alumni banquet, to see all the boys again. Give my best wishes to all, and kindest regards to you and Mrs. Brack. Hoping to hear from you, I am,

Yours sincerely,

CHAS. W. VOGEL,

P. A. Surg., P. H. & M. H. S.

SOUTH CHARLESTON, OHIO, March 30, 1908.

WILLIAM S. GARDNER, M. D., 6 West Preston St., Baltimore, Md.

Dear Doctor.—Some one suggested in an issue of the ALUMNI JOURNAL that the class of '93 have a reunion in Chicago at the meeting of the A. M. A. this summer.

I am heartily in favor of such a move, as Chicago is a central point. Let some of the boys take the matter up, and make arrangements for a grand time; say we include the classes of '94 and '95, as we were all there together. Whoever happens to see this drop me a line, and we will get together. Perhaps we may find some one of our class in Chicago who will help in the arrangements. Doctor, kindly put this letter in the next issue of the ALUMNI JOURNAL, and send me a statement of my dues, as I want the JOURNAL.

I am respectfully,

JOHN J. MOORE.

DANIELSVILLE, PA., Jan. 31, 1908.

DR. CHAS. E. BRACK.

Dear Doctor.—Enclosed find check for \$1.00 for the JOURNAL, hoping you will overlook my indifference in the past. I was very much grieved to learn of the death of Dr. Latimer. While at college I was taken sick with nervous prostration, and the care he gave me I never shall forget. I thought I could not graduate, but he told me to remain, which I did,

and when the announcement came I found myself O. K. with the boys of 1897.

I am enjoying a fine practice at the foot of the Blue Ridge Mountains, in Northampton County, Pa., where I located in October, 1897. Am married and have one son seven years old. I am very anxious to hear from my room-mate, Dr. B. B. Hudson, of Americus, Ga. The last letter I had from him he told me he would leave for the Philippines. I lost his address, hence I cannot communicate with him.

I shall be very glad to hear from any member of the class.

Fraternally yours,

M. E. KEMERER, M. D.

SCRANTON, PA., Feb. 23, 1908.

DR. CHARLES EMIL BRACK, Baltimore, Md.

My Dear Brack.—The JOURNAL called at my house this morning and after a pleasant half-hour in its company I cannot refrain from writing you just for old friendship's sake, and also to place my name on the list of "accounted for."

Well, to be brief, I tussled with general practice in the wilds of northern Pennsylvania for five years, after our "escape" in '95, then took a short vacation of five years, during which time I took a short trip to the other side, attended the excellent free clinics in New York City, and took a post-graduate course at the New York Post Graduate Medical School. On September 1, 1905, I started practice here in Scranton, where we have two flourishing medical societies, the Lackawanna County Medical and the Scranton Clinical and Pathological. In the latter we are having a splendid post-graduate course, by each member (about 60 in all) "chipping in" \$25.00, for which we have been able to obtain the services of some of the best teachers in the country.

In the County Medical we are conducting a "home made" post-graduate course, following out the plan of a well-known Southern man (Blackburn, I think).

Am enjoying the life here in Scranton, and often think of the old days on "the benches," when the boys of '95 used to make little pleasantries about the three B's; "Burdock" Bowerman, "Blood" Brack, and

"Bitters" Bryant, always being on the bald-headed row. And, by the way, where is Bowerman?

The memories of the dear old P. & S. are always alive in my mind, and during the years of my practice the words of Latimer, Rohé, Chambers, and the rest have often come back to me to aid and console me in anxious moments when no other consultant was available. Remember me to any of the boys you see and let me hear from you. As ever,

Your friend and classmate,

FRANK G. BRYANT.

FORT SAM HOUSTON, TEXAS, Jan. 5, 1908.

My Dear Doctor.—I left the Islands on October 2, of last year and arrived in the good old United States on the twenty-ninth of the same month. After leaving Japan I was taken with amoebic dysentery, and the two months leave I was granted was spent in bed. I have gotten over the acute stage and am now able to do duty, though I am still troubled to some extent with it. I was in Washington for a few days and had hoped to be able to get over to see all of you, but my condition prevented me from doing so. I am now stationed at the above post and hope to remain here until I fully regain my health. Enclosed find one dollar for the JOURNAL and please forward it to the address above. If I owe you any more please let me know, as I do not remember how we stand, and I have not received my papers from the Islands. With best wishes for a prosperous New Year to you and all at P. & S., I am,

Faternally yours,

CHARLES H. HALLIDAY.

VANDERGRIFT, PA., March 23, 1908.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor.—I enclose \$2.00 for arrears of JOURNAL. I have not read them very regularly, it being my own fault. Should I owe anything more please send bill. I am of class of '85, and should be very glad to hear of any members of that class, or of '84 or '86, many of whom I knew. Perhaps many of them, as of the old faculty, have gone up higher.

Dr. A. E. Heilman, of '84, died of typhoid fever at his home in Rural Valley, Pa., about three years ago. Would be glad to hear from Mc-

Manus, of South Addison, N. Y., or F. D. Snell, of Iowa. Among others whom I can recall, are Buck, of Virginia; Anderson, Johnson ('84), Steiger, and Sooy, of New Jersey; Fallmer ('84), of Cornucopia, Ga.; Haughenhaupt and Bressler, of Pennsylvania; Jno. M. Crooks, of Alabama; Jno. W. Coughlin, of Massachusetts, and many others whose faces are familiar in memory, but whose names escape; and the old professors, Lynch, Opie, Arnold, Coskery, Friedenwald, Erich, Latimer, Gundry, Bevan, Simon, Rohé, Chambers, and Branham. I remember them all. I think, perhaps, their instruction has not entirely faded from my memory.

Maybe at some future time I shall write again. Best wishes, Doctor, to you all. Special regards to Dr. Wm. S. Gardner, of '85.

Yours,

J. M. PATTON.

A NEW METHOD OF TESTING THE FUNCTIONS OF THE DIGESTIVE APPARATUS.

Einhorn (Therapeutic Gazette, January, 1908) submits a method for investigating the functions of the intestinal tract, the principle of which is the administration of test substances with the food and observation of the effects of the digestive fluids upon these substances.

Practically this test is made as follows: Patients are given in a gelatin capsule a string of beads with the following substances attached thereto: catgut, fish-bone, meat, thymus, potato, mutton fat. After administering the capsule, every stool is examined with the stool-sieve until the bead-string has been recovered. If diarrhea is present the sifting may not be necessary, as the bead-string can readily be seen (usually at the bottom of a glass vessel).

Under normal conditions the bead-string appears after one or two days. It is then rinsed in cold water and examined. If digestion is normal we find that catgut, meat, and potato (except the skin) disappear entirely, thymus and fat almost entirely, whereas the fish-bone usually disappears, but occasionally it may be present. The nuclei of the thymus always disappear. In pathological conditions deviations from the normal are observed, not only in regard to the time of recovery of the beads (disturbances of motility), but also in regard to the presence of the food substances (disturbances of the digestive function).

The author divides his cases of intestinal digestive disturbance into two groups:

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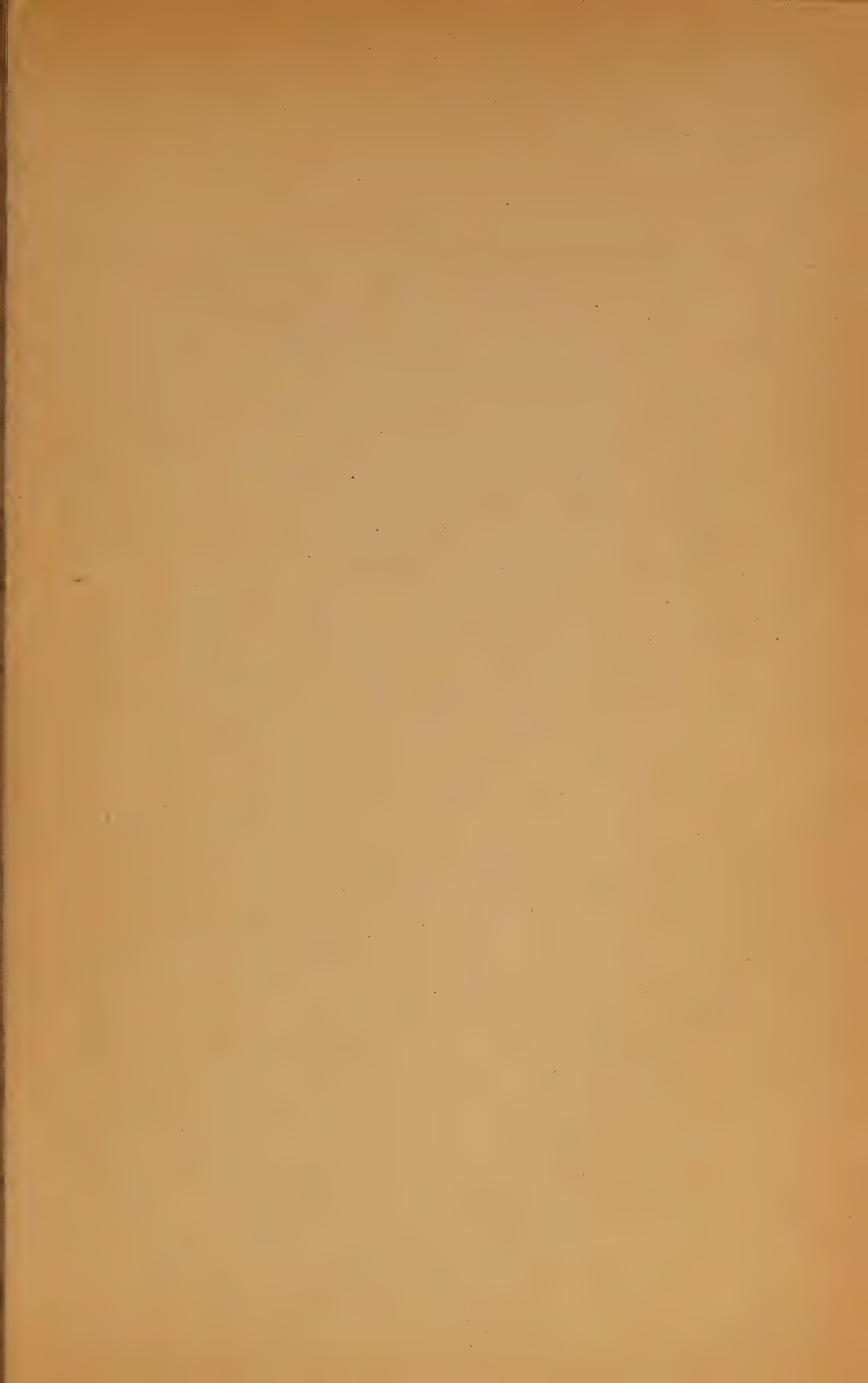
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A PLEA FOR MORE CARE IN THE EARLY DIAGNOSIS OF
UTERINE CANCER.*

By J. B. EAGLESON, M. D., SEATTLE, WASH.

When we face the fact that of all women over thirty-five years of age, one in every thirty to thirty-five is doomed to die from cancer of the uterus, and also that of the patients who are afflicted with this terrible disease from 50 to 75 per cent reach the surgeon too late for a radical operation to be of any benefit, we are very forcibly impressed with the great necessity for more care in the early diagnosis.

About eight or nine years ago I read a short paper before this society on the necessity for more care in the early diagnosis in cancer in general, but at this time I wish to limit my remarks to cancer of the uterus. Of the inoperable cases of uterine cancer about one-third will die within one year, and three-quarters within two years after the first manifestation of the disease. Only a few will outlive a three-year period. It is usually considered that the disease runs a much more rapid course in younger patients than in those more advanced in years. According to Kelly, the cylindrical cell form is more malignant, and probably runs a shorter course than the squamous cell form, and the inverting type is probably more malignant than the everted. About one-third of all primary cancers develop in the uterus.

The etiology of the disease is as yet unknown, although it is pretty generally acknowledged that traumatism of the cervix has some relation as a predisposing cause. And yet the cancerous growth appears to de-

* Read before the Washington State Medical Association, Seattle, Wash., September 10-12, 1907.

velop more frequently from the site of an erosion or ulceration than from an old scar in the cervical tissue. The disease is very rare in women who have not borne children nor had abortions. I have seen two such cases, but in both the cervix had been dilated and uterus curetted. In one there was a cauliflower growth on the vaginal portion of the cervix and in the other the disease developed in the fundus and extended to the peritoneum, forming miliary metastases on the peritoneal surfaces of the abdominal organs. Dr. D. W. Graham, of Chicago, reports a case in a nullipara aged 43, whose cervix had never been dilated.

In 98 per cent of cases the disease develops in the cervix, thus facilitating the diagnosis by palpation and inspection, even in quite an early stage. It is practically impossible to form a diagnosis from the subjective symptoms alone, as there is seldom pain or discomfort felt by the patient until the disease is well advanced.

Bleeding is present, in some form, in about 93 per cent of the cases. This varies from only an occasional slight showing to a more constant discharge, or it may at times become as free as a menstrual flow, causing the patient to think that she is suffering from an irregular menstruation, or a return of the menses after the menopause. It may be present in the form of severe hemorrhages throughout the case. Fortunately for the patient bleeding is a very early manifestation of the disease, since it is a symptom so readily noticed, and one to which immediate attention is given by both the profession and the laity.

A slight watery discharge sometimes precedes the flow of blood for a few weeks or even months. This may become a yellowish or whitish leucorrhea, which soon becomes a dirty, stinking, bloody discharge, at once suggestive of carcinoma, and should always be regarded with suspicion. When there is any such history a thorough examination should always be insisted upon.

When the growth is on the vaginal portion of the cervix there will be but little difficulty in arriving at a correct diagnosis. The indurated or excavated ulcerations of the cauliflower growth, with the friable condition of the tissues and the tendency to bleed at the slightest touch, leave but little doubt as to the true character of the disease. If there be any doubt, a small piece should be excised and examined microscopically.

When the growth is located in the cervical canal, where it is not accessible to sight or sense of touch, the diagnosis is rarely made early. When

the destruction of the tissue becomes evident at the os the disease may be well advanced. When this condition occurs there is usually no need to resort to the microscope to confirm the diagnosis.

When the growth is located in the body of the uterus the diagnosis is extremely difficult, and is apt to go unrecognized until past all hope for a radical operation. In such cases the constitutional effects appear very much slower, so that the patient may retain her weight and general good appearance until the last stage of the disease.

In all cases any irregular hemorrhage should be noted with suspicion, the cervix should be dilated, and the uterus curetted for the purpose of making microscopic examination of the scrapings in order to arrive at the diagnosis.

One author tersely puts the question as follows: "If every menstrual irregularity occurring late in life, and every intermenstrual or postmenopausal hemorrhage were regarded with suspicion of carcinoma, and a thorough search made into the cause, few carcinomata of the uterus would long go unrecognized." That these cases do go unrecognized, both by the laity and the physician, is very evident.

During the past two or three years I recall twelve cases of uterine carcinoma, nine of which were inoperable when they came to my care. One consulted me for the first uterine hemorrhage, which came from a growth in the fundus. I insisted on curetting the uterus for the purpose of diagnosis, but she objected and went to another physician, who examined her and told her there were no signs of cancer present. When I saw her next, about six or eight months later, the hemorrhage was profuse and the organ was so far invaded as to make an operation impossible. One case was brought to the hospital for repair of a cervical laceration. One had the cervix repaired a few months before, but it did not heal. She was then kept in the hospital for several weeks and treated for change of life by two other physicians. When she came under my observation the whole cervix had sloughed out, leaving simply a ragged hole in the vault of the vagina.

One patient was informed by a physician that there was only a slight ulceration of the cervix, which could be healed in a short time by treatment. This case was operated upon, and we found not only the cancerous growth in the cervix, but also a mass of malignant tissue in the fundus.

Several of the patients had suffered with hemorrhages and discharges for several months before seeking the advice of a physician. One, who had a cancer of the fundus, had suffered severe pain for over a year without thinking there was any serious trouble.

Kelly states that, in 412 cases seen in his clinic, over sixty per cent gave a history of neglected uterine bleeding lasting six months or over. Just think how many of these might possibly have been benefited, and some saved, had nature's red flag only been heeded by patient and doctor.

Let us sound the warning far and near so that an early diagnosis may be made in this dreadful disease, which is taking away so many wives and mothers. Kelly says that: "The community at large should be so trained by the profession that any woman who suffers from an unusual or atypical hemorrhage, or from an unusual discharge, should at once seek competent advice as to its source, and the physician should not rest until he has definitely ascertained its source. This rule holds good with increased force in the case of women in the forties, when both patients and doctors are so often deluded into blind waiting for nature to relieve that which in time proves to be beyond the resources of both nature and art. If these rules were conscientiously observed, there can be no doubt but that thousands of lives could be saved yearly in this country alone, for cancer of the uterus is a disease markedly local, accessible and eradicable in its earliest stages." Clark states that the education of public opinion in medical subjects depends upon the general medical practitioners.

Winter, believing that with the first appearance of symptoms uterine cancer is always curable, started a remarkably successful campaign of education in East Prussia, in 1902. He sent instructive pamphlets to all the physicians and midwives in the district, and followed it by instructions to women in the public press. It stirred up so much interest that both the physician and the laity became wide awake to the subject of early diagnosis, and the result was that in one year, in East Prussia, the operability of cancer increased from 62 to 74 per cent. Note the great difference between that and our own 25 or 30 per cent of operable cases.

Should we not at least keep abreast with the good work of our German confreres and do something to educate the laity on this subject? I suggest that this association might accomplish a great deal of good in this direction by some systematic methods. We have our tuberculosis com-

mittee and our venereal committee for the prevention and relief of diseases which are not so disastrous in their results. Here we have a disease which, if once developed, nature, hygiene, outdoor treatment, etc., are powerless to check. Only an early diagnosis and the surgeon's art can keep the victim from death in two or three years, and this can be in some measure accomplished by training both the physician and the laity to be on the lookout for the first symptom of the disease.

RAYNAUD'S DISEASE.

By DR. HORACE C. NICHOLSON, '06.

Synonym.—Local asphyxia and symmetrical gangrene of the extremities.

History.—This very interesting and rare disease, only about 250 cases having been reported until 1904, was first described by Sir Benjamin Brodie in 1837; but it was not considered a separate disease until 1862 when Maurice Raynaud, in his Paris Thesis, directed attention to its phenomenon and demonstrated its separate entity. Since then it has been known as Raynaud's disease.

Etiology.—Raynaud's disease occurs at any age, but more frequently between 18 and 35. Neither sex is exempt, although females are more frequently affected. There is no single factor, or group of factors that may be said to have any definite connection with the production of, or association with, Raynaud's disease. It has been found in individuals that have had acute specific fevers, lues, neurasthenia, insanity, menstrual disorders, scleroderma, carcinoma of the stomach, and paroxysmal hemoglobinuria. Paroxysmal hemoglobinuria is the most interesting disease with which Raynaud's disease is associated. Syphilis is very often the cause of hemoglobinuria. This dual relationship of hemoglobinuria has caused some one to suggest that Raynaud's disease may be the result of syphilis, either acquired or hereditary.

Paroxysmal hemoglobinuria was considered by Abercrombie one of the symptoms of Raynaud's disease. Many writers have noted the two conditions in the same individual, although not simultaneous. Morgan in Quain's dictionary makes the following statement: "Many victims of Raynaud's disease may be looked upon as hysterical, emotional, and

excitable persons in whom the neurotic element is highly developed." Osler says it is "a vascular disorder, probably dependent upon vaso-motor influences." Raynaud considered it a local spasmodic constriction of the blood vessels of the parts. Peyton thinks there is a separate set of trophic nerves and centers, and that the disease is due to a lesion either centric or peripheric. In substantiation of this theory he cites the trophic influence of the fifth nerve over the cornea and eyeball.

Another, and probably the most important etiological factor in the production of Raynaud's disease, is exposure to cold. Many cases have been known to recur during the winter, while in summer there was no evidence of the disease. Voelker says: "The paroxysmal nature of the attack, the return to normal condition in the intervals, the absence of any degenerative changes in the vessels in most cases in young subjects, and the direct observation of the altered pulse in the part and of the changes in the veins, as well as the evidence of vascular spasm obtained by ophthalmoscopic examination made during an attack of local asphyxia, all point to the morbid condition being one of active spasm of the vessel walls with diminution or arrest of the flow of blood through the affected vessels. The influence of cold or emotion in inducing an attack points to this condition of vascular spasm as being a reflex act, the vaso-motor centers being in an unduly irritable condition so that the vascular spasm is readily induced and maintained. The symmetrical character lends additional probability to the central nature of the change. Changes once initiated tend to recur with undue readiness, and thus we get from a slight cause recurrent attacks of vaso-motor spasm."

Of the two cases coming under my observation, one gave a luetic history; the other at times declared she had never had lues or was not positive. She lived a life of prostitution before coming to the hospital.

Morbid Anatomy.—As to the pathology, little or nothing is known. In some cases endarteritis has been shown to exist in all three coats of the arteries, while in other cases the arteries were normal. Endarteritis was found in both luetic and non-luetic cases. No constant changes have been noted in either the peripheral or the central nervous system. The skiograph has shown atrophy of the terminal phalanges.

Symptoms.—The disease is characterized by disorder of the circulation in the peripheral parts, frequently symmetrical in distribution and depending upon paroxysmal diminution or arrest of blood to the parts.

Three grades of the disease are recognized: (1) Local syncope; (2) local asphyxia; (3) local or symmetrical gangrene.

Local syncope is characterized by a numbing or tingling sensation and a blanching of the affected parts, which are cold, while adjacent areas may be hyperemic and hot. The condition is similar to that produced by great cold, and may be excited by exposure to cold or the mere washing of the hands in cold water. Emotional, gastric, or intestinal disturbances may be a factor. The extremities, nose, and ears are most frequently affected.

Local Asphyxia.—This is the most common form and it may succeed syncope, but usually follows a passing pallor. Asphyxia is characterized by its cyanotic appearance, varying from a slight coloring to almost black. Pressure on the affected area is followed by pallor returning slowly to the color of the surrounding area. The affected areas are most exquisitely painful, exceptionally anæsthetic, sometimes edematous, and very cold. In one of Raynaud's cases the temperature was 27° F. below that of the axilla. Pressure and warmth usually intensifies the pain and cold usually soothes. With the case now under my care, I find that heat soothes some areas while intensifying the pain in others, and there is sensitiveness to even slight pressure. This condition may pass off, which it most frequently does, or go on to gangrene. Attacks of cyanosis are sometimes accompanied by hemoglobinuria, scleroderma, urticaria, fibrous ankylosis of terminal phalanges, amblyopia, and iridoplegia. The extremities are most frequently affected, but areas are found on the body. In one of my cases, at each attack, quite a number of local areas of asphyxia were found on the trunk.

Local or Symmetrical Gangrene.—This variety is never primary, but may follow either repeated or prolonged attacks of local syncope, or more frequently local asphyxia. The gangrenous areas vary in size from that of a small spot on the ball of one or more toes or fingers, or on the body to gangrene of one or several toes, fingers, or even the greater part of one or more extremities. The gangrene is frequently, but by no means always, symmetrical. The onset of gangrene is usually manifest by the formation of blebs containing a blood-colored, sterile serum. The surrounding tissue becomes dry and hard, and a line of demarcation appears. The black tissues are, of course, insensible, yet the surrounding tissues are often exquisitely painful to touch. Mention may also be made that

internal lesions, similar to those affecting the extremities, have been suspected. I was unable to find any literature on this question. One peculiar feature about the temperature chart in all uncomplicated cases is the absence of pyrexia.

Diagnosis.—Very little difficulty should be observed in the diagnosis of Raynaud's disease. Gangrene occurs in diabetes, nephritis, syphilis, multiple neuritis, endarteritis obliterans, sometimes in alcoholics, more rarely in syringomyelia and ergotism. Senile gangrene may also occur, but Raynaud's disease occurs in the young. All the above mentioned conditions can readily be excluded by well-known clinical, therapeutic, or laboratory methods.

Prognosis.—As regards the patient's life, the prognosis, except in those rare cases occurring in childhood which terminate fatally within 24 to 48 hours, is good. Many cases recover entirely, others remain liable to recurrence for many years. Death, if it occurs, is probably due to complications, as tuberculosis, carcinoma, exhaustion, scleroderma, or sometimes to extension of gangrenous processes. The patient may be rendered, by loss of limbs, unable to perform the ordinary duties of life.

Treatment.—The treatment of this disease is very unsatisfactory. Mild attacks should be kept in bed with the parts elevated. The extremities should be kept warm by wrapping in cotton wool. Careful and systematic massage is useful. Nitroglycerine and the nitrites are recommended by many. Barlow advises placing the affected parts in warm salt solution and the negative pole of a galvanic current in the water, with the positive pole on healthy tissue. The current should be frequently interrupted and reversed, should cause contractions of the muscles and redness of the skin. Galvanization of the sympathetics has given some results. Hist recommends local application of alcoholic solution of menthol. Newman says the long continued doses of opium act favorably. Hot saline douches over the affected parts with alternating hot and cold douches over the spine are advised by Peyton. In a case reported by Brownson the X-ray was used with bad results. Osler says morphine may be required for the pain.

When the gangrenous stage is reached, non-irritating, dry dressings should be applied and should wait for line of demarcation to appear. Healing takes place by sloughing and granulation. The resulting loss of tissue is much less than would at first be expected. Amputations should

be done only after the line of demarcation has become very definite, and then as much tissue should be saved as possible. After treatment is the same as in ordinary amputation.

CASE I.—M. S., female; age 32; single.

Family History.—Negative.

Past History.—Escaped all ordinary children's diseases. Had typhoid fever, and had pneumonia twice. Dysmenorrhea always. Had four full-term children and three abortions. All children died within two years. Denies any venereal disease. No history of hemoglobinuria.

Present Condition.—About ten years ago, she noticed on awakening one morning that the last two phalanges of the right little finger were blanched and numb. By night it was red and the next morning gangrenous. It was amputated without an anæsthetic. The hypothenar side of the hand and wrist were numb. About two weeks later the ring and middle fingers went in the same manner. The left hand was lost with exception of the thumb. Each winter she has lost portions of her hands or feet until now there remains only stumps for feet and the hands are missing except one thumb and some of the metacarpal bones. Many areas of asphyxia could be found on the limbs and body during the winter. Some areas became gangrenous and the skin would slough. Dry applications were all that was necessary. The patches were very sensitive to the slightest pressure. They were not symmetrical. No internal treatment seemed to relieve. Morphine was given for pain. Internal lesions of the first degree were suspected. An exploratory laparotomy was done, appendicitis being suspected. Nothing was found, however, except a mass of adhesions and a slight inflammatory condition. Healing was accomplished without complications. This case has pulmonary tuberculosis which has been arrested by dietetic and outdoor treatment.

CASE II.—E. M. S., male; age 36; widower; Irish; bartender and salesman.

Family History.—Mother was a neurasthenic.

Past History.—Has had varioloid, measles, whooping cough, diphtheria, malaria and quinsy. Had acute rheumatism when 17 years old. Severe attack of gonorrhea at the same time he had rheumatism, but the rheumatism preceded the gonorrhea. Had the initial lesion of syphilis eighteen years ago. Took treatment for one and one-half years.

In April, 1905, had what he thought was neuralgia of the face. Later the pains extended over the entire body, most severe in the legs. There was no swelling or pain of the joints. On the third day the right arm became affected with loss of function of hand and forearm. There was numbness, pallor and coldness in this arm for probably a month. The function and sensation returned gradually and when admitted to the hospital only the second finger, back of the hand and an area on the forearm remained sensitive and pale. The left foot, at the same time, became very painful, cold and blanched. The next morning the foot was cyanotic and burning hot, with lancinating pains. The second toe was amputated for gangrene a few days later. Three months later the third toe became gangrenous and the patient was sent to Bay View Hospital. On admission the third toe was found to be gangrenous and the line of demarcation fairly definite. The whole limb was very painful and morphine was necessary to quiet the patient. A few days

later Lisfranc's amputation was done. The wound was closed with silk. After amputation the foot was painful and morphine was required. The wound was healthy looking at the first few dressings, but became cyanotic and edematous, and the stitches were removed to relieve tension. Granulation began, but the new tissue was not healthy in appearance. Some days the foot would be very dark, then again would appear nearly normal. The stump never entirely healed and the leg was amputated at the lower third after two months of suffering. The patient entirely recovered from this attack.

There may be some doubt as to whether or not this was gangrene due to Raynaud's disease or was of a syphilitic origin, since potassium iodide was begun when he entered the hospital.

TRIMBLE MEMORIAL MEETING.

A memorial meeting for Dr. Isaac Ridgeway Trimble was held in the College Amphitheatre, Tuesday, May 12, 1908, at 8.30 p. m.

The chief feature of this meeting was the presentation of a portrait of Dr. Trimble by the students of the College to the Faculty; the portrait to be hung in the College library.

The president of the senior class, Mr. J. J. O'Malley, made the presentation speech, and the portrait was accepted on behalf of the Faculty by Dr. George J. Preston. After this ceremony there were addresses by Dr. Charles W. Mitchell, Dr. Charles O'Donovan, and Dr. W. S. Thayer.

The meeting was largely attended by students, members of the medical profession, and the laity. It was presided over by Dr. Charles F. Blake, president of the medical society at the College.

Presentation of portrait of Dr. Trimble by J. J. O'Malley, '08:

In behalf of the students of the College of Physicians and Surgeons, I present this painting of Dr. Trimble, as a manifestation of our high esteem and unfeigned affection for our deceased Professor.

But no memorial of him with which we may embellish these walls, no words which we may utter on this occasion, can adequately express the profound grief produced in us by his untimely death. We may reveal clearly and forcibly the lighter sorrows that ruffle the serenity of the mind, but our more intense feelings are merely outlined by words. When the sorrow becomes more grave, when the spirits are depressed by the intelligence of the death of a dearly beloved friend, the soul becomes so confused that our expressions but vaguely disclose the deep gloom and heartrending anguish.

For nearly four years, we have known him and admired him. His prosperous labor has merited the unstinted praise of the students. We have respected him for his subtilizing intellect; we have drunk with pleasure and satisfaction at the limpid stream that flowed from his seemingly inexhaustible fountain of knowledge.

He was particularly devoted to his duties in the College; his work was done with an earnestness that could not fail to win our respect and to leave a deep impression on our minds.

He possessed too, that comprehensive tenderness which endeared him to all whom he met; and, we would be very ungrateful if we did not consider ourselves under great obligations to him. We owe him more than we could ever hope to repay, more than we can even manifest.

We have loved him for his hearty consideration of our welfare, and for his high ideal of the Medical profession, in the practice of which, he so unfortunately met his death.

His mission upon earth has been faithfully performed; he has passed away, leaving rich legacies of thought; he has gone and a host of sorrowing friends remain.

Dr. Preston said in part:

As the representative of the Faculty, I present to you this memorial of him whose death has deeply affected us all. May the painting recall to the Faculty of this Institution, his inestimable labors; may it remind the students of this year of the many favors they received from his hands; may the students of the future know, as they gaze upon this tribute of love, that in 1908, the commencement day arose from the darkest gloom, caused by the death of Dr. Trimble.

Dr. C. W. Mitchell then made the following remarks:

To be asked to speak upon such an occasion as this is an honor which I most deeply appreciate.

The characteristic of Dr. Trimble upon which I wish to address you is that which we might term the "Moral youthfulness of the man." Twenty-five years of intimate friendship is a period sufficiently long to enable one to form fairly accurate judgments as to moral characteristics and tendencies.

My acquaintance with Dr. Trimble began when he was in the first year of his life as a medical student. He had just come to Baltimore from that home of exquisite refinement, distinguished ancestry, and noble traditions, where his boyhood had been spent. His early environment had left its marks upon him, and he was at once recognized as a young man of magnificent physique, the highest social graces, fine mental capacity, splendid energy, and of the loftiest purposes and ideals. He soon took a position of moral leadership among his fellow students.

After his graduation in medicine, and as the years rolled on, his moral force seemed to gather strength. There was no waning of his youthful ideals. They were, on the contrary, deepened, refined and made full of purpose and achievement.

No hope of professional honors and distinctions, no greed of gain, no selfish desire or ambition ever blunted his exquisite moral sense of touch, ever dulled his keen perception of right and wrong, or impaired his unerring discrimination between the essential and the unimportant. And it was this superb moral poise that kept him young. In his ethical make-up, his arteries did not become sclerosed, his heart hardened, his nerve cells degenerated, but all maintained their boyish pliancy and elasticity until the end. It was this fact that enabled him to combine the unselfish altruism of the youthful

dreamer with the energy and achievement of the man of affairs; to meet the storm and stress of modern professional life in a manner accomplished by no other man in this community; and to be looked upon in city and State, as a great moral force. It was this fact that made him the optimist he was, that gave him the genius for friendship that always rang true, that made it possible for him to combine the strength of a giant with the gentleness of a little child, and that made his life a benediction upon all with whom he came in contact.

While cherishing deep religious convictions, Dr. Trimble had neither time for nor inclination toward fine theological theories and dogmas. His was a life of service. In his every act as physician and as man, he seemed moved by the example of the Divine Master and Physician, who said: "Inasmuch as ye have done it unto one of the least of these, My brethren, ye have done it unto Me."

GEORGE JUNKIN PRESTON.

It will be a great shock to the alumni to learn of the death of Dr. George J. Preston, Professor of Nervous Diseases and Physiology. He had been ill but a short time, something over a month, having had some trouble with his liver, and died on the evening of June 17.

Dr. Preston was born in 1858 in Lexington, Va. His father was Colonel J. I. L. Preston, formerly superintendent of the Virginia Military Institute and professor in the Washington and Lee University and his mother was Mrs. Margaret Junkin Preston, a sister-in-law of General Stonewall Jackson, and was prominent as one of the poets of the South.

His early education was received at the Washington and Lee University, where he received a degree of A. B. in 1879. The following year he entered the University of Virginia, and then went to the University of Pennsylvania where in 1883 he received the degree of Doctor of Medicine.

The next two years were spent in Philadelphia as resident physician of of the Presbyterian Hospital. He then removed to Baltimore and was interested in a dispensary located on South Hanover St. It was here that he became interested in nervous diseases, and in 1885, after a short residence in Baltimore, he went to Europe to study neurology. He was a student of Charcot in Paris and later on studied at Leipzig. Whilst under Charcot he took considerable interest in hypnotism and developed remarkable facility in the production of the hypnotic states, which he occasionally used in demonstrations at the College and in the treatment of his patients. Whilst in Leipzig he met Miss Emma Heinrich, whom

he afterwards married, and who survives him. After his return from Europe he was made Professor of Physiology in the Woman's Medical College, Baltimore, and in 1889 Professor of Physiology and Diseases of the Nervous System in the College of Physicians and Surgeons. In 1898 he succeeded Dr. Wm. Lee as secretary of the Lunacy Commission, and the following year, under the administration of Governor Lowndes, Dr. Preston caused the revision of the Code of Laws relating to lunatics in Maryland and urged the State care of the insane. He was thoroughly familiar with the condition of the insane throughout the State. He made frequent visits to the county almshouses and was an eloquent advocate, both in his writings and his addresses, of the State care of the insane, favored the removal of all insane persons from the custody of the counties and placing them in modern State institutions. His efforts met with success and the necessary legislation was secured, but owing to lack of funds the last Legislature postponed this important step in the care of those unfortunates for several years. Dr. Preston may, however, be regarded as doing for Maryland what Pinel did about 100 years ago for the insane of France.

Dr. Preston was an active member of the Medical and Chirurgical Faculty, was vice-president, 1897-1898, and chairman of the Library Committee, 1889-1906. He had extensive hospital connections, being Visiting Physician to the City Hospital, Nursery and Childs' Hospital, Bay View, Hebrew and St. Agnes Hospitals.

As a practitioner, he was among the most successful in the city, but in the more recent years he limited his work entirely to nervous and mental cases. He had an extensive consulting practice, and was frequently called on as an expert by the courts, being regarded as one of the best expert witnesses in the State. His remarkable ability and good judgment in the handling of the nervous and insane won for him a high place in the profession, and his death will cause a loss which will be extremely hard to replace.

As a teacher Dr. Preston was very popular. He was able to make clear and simple to the students the complicated problems of physiology and neurology, and his lectures were not only clear, but had in addition the charm of being interesting and were frequently enlivened by stories illustrating some point which he wished to impress upon his class.

His most important contribution to the medical literature is his book on "Hysteria." It is one of the best contributions to this subject made in this country.

Socially he was very popular. He had a great many friends and few, if any, enemies. He was a member of the University Club and of the Medical Reunion.

Besides his widow, Dr. Preston leaves a son, George J. Preston, Jr., and a daughter, Miss Margaret Preston; a brother, Mr. Herbert R. Preston, and one sister, Mrs. William Allen.

THE STANDING OF P. and S. GRADUATES AT THE STATE BOARD EXAMINATIONS.

Graduates of all years, 10 per cent; 1902-1907, 11.2 per cent; 1901 and previous years, 100 per cent passed—no failures—examined 10; 1907, 9.1 per cent failed. In Maryland 9.1 per cent failed; in other States 11.6 per cent failed.

Statistics compiled by the A. M. A. show that our record is second in the State to the Johns Hopkins Medical Department of the schools belonging to the Association of American Medical Colleges.

Maryland, 10 took examinations, 1 failed; New York, 7 took examinations, 0 failed; Pennsylvania, 16 took examinations, 2 failed; West Virginia, 19 took examinations, 0 failed; Virginia, 4 took examinations, 0 failed; North Carolina, 4 took examinations, 0 failed.

REPORT OF THE TREASURER.

Collected for advertisements and dues.....	\$640.83
Balance, May 1, 1907.....	57.62
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	\$698.45
Expenses, printing and mailing Journals.....	680.84
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Balance, May 1, 1908.....	\$17.61

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

FLEXNER'S ANTIMENINGITIS SERUM.

At the meeting of the American Pediatric Society, Flexner made a preliminary report on his antimeningitis serum, and reported the results in 322 cases.

Whilst it is a little early to speak of the value of this means of treatment, the results which have been obtained by various observers have been so uniform and so striking that they are worthy of great consideration. Billings collected 2350 cases which, with ordinary means of treatment, had a mortality of 75 per cent. In 350 cases that recovered the duration in 50 per cent was five weeks longer. In 83 cases in baby hospitals all in patients under one year of age, there were no recoveries. These figures correspond very largely to the experience of other observers. Under one year of age the disease is almost uniformly fatal, recovery being very exceptional; whilst under two years of age the mortality is always very high.

In reporting the experience of the Boston Children's Hospital, Dunn stated that for a number of years the average mortality had been 80 per cent or over; whilst with systematic lumbar punctures this had been reduced to between 70 and 80 per cent. Since the use of the serum the mortality has been reduced to 19 per cent. In the collection of 322 cases there were 68 deaths, a mortality rate of 27 per cent; 13 cases were under one year of age; of these 5 died and 8 recovered, a mortality of $37 \frac{5}{10}$ per cent. There were 26 cases between one and two years of age with a

similar mortality. The best results were observed between five and ten years where in 62 cases the mortality was only 11 per cent. The effect of the serum is not only striking as regards its effects on the mortality, but also on the course of the disease. The fever disappeared rather quickly in from two to five days, or in other cases in from three to six days; and with this there was a disappearance of symptoms, whilst the signs of the disease persisted somewhat longer.

The serum is not an antitoxic serum, but an antibactericidal one and acts directly on the bacteria. It is slightly antitoxic and animals may be protected from death from ten to twenty fatal doses, but in larger doses of toxin it has no effect. The effect is not noted by putting it into the circulation as owing to the large size of the molecules of which it is composed, dialysis is exceedingly slow, and a sufficient amount does not find its way into the lymph spaces where the meningococcus is found. It is, therefore, found necessary to inject it directly into the subdural space; the method used being to do a lumbar puncture and to withdraw 20 or 30 cubic centimeters of cerebrospinal fluid and then to replace this by an equal quantity of the serum. There were no symptoms following the injection, although some observers noted pains in the legs, urticaria, and some disturbances in the rectum, but as Dunn suggested, this may have been due to the use of cold serum.

Taken all in all the report is one of the most encouraging things that has been announced to the medical world in some time, and it is to be hoped that future investigation will show this serum to be of great value in the treatment of a disease which has heretofore entirely baffled the skill of all physicians.

THE PROFESSORSHIP OF PHYSIOLOGY AND NERVOUS DISEASES.

The College is very fortunate in having secured Dr. Wm. P. Spratling to fill the vacancy caused by the recent death of Dr. Preston.

Dr. Spratling is a man eminently fitted to take charge of the work, as he has had a large experience in dealing with people, is thoroughly familiar with mental and nervous diseases through his long service as a superintendent in institutions devoted to their care, and as a specialist in diseases of the nervous system.

He was born in Alabama 45 years ago and received his degree from the College in 1886. The following year he was resident physician at the City Hospital, and in 1888 he entered the Marine Hospital Service in which he served for two years, resigning his position to devote himself to the study of nervous diseases. Shortly after he was appointed resident physician at the State Insane Asylum at Morris Plains, N. J., where he remained for several years. In 1896 he was called to take charge of the new Craig Colony for Epileptics, one of the largest and best managed epileptic colonies in the world. It has been under Dr. Spratling's direction that this institution has attained the high place which it holds in the treatment of this unfortunate class. Dr. Spratling will come to Baltimore and devote his time to the practice of neurology and to his teaching work at the College.

THE COMMENCEMENT.

The Thirty-Sixth Annual Commencement of the College of Physicians and Surgeons was held at Albaugh's Theatre, Wednesday evening, June 3, 1908, at 8 o'clock.

ORDER OF EXERCISES.

Prayer,

REV. THOMAS E. PATTISON, D. D.

Music.

Announcement of Graduates and Conferring of Degrees,

PROF. CHARLES F. BEVAN, M. D., DEAN.

Music.

Award of Prizes,

PROF. WM. SIMON, PH. D., M. D.

Music.

Oration,

REV. L. E. BARRETT.

Music.

Benediction.

The members of the graduating class, 1908, are as follows:

Austin, S. C., West Virginia.	Barber, Oscar T., New York.
Burner, A. E., West Virginia.	Brown, Richard J. (M.D.), W. Virginia.
Bancroft, C. R., New York.	Brown, Homer S., West Virginia.
Bevan, Daniel L., Pennsylvania.	Coppedge, Thomas O., North Carolina.

- Chideckel, Maurice, Maryland.
 Cohn, Charles W., Pennsylvania.
 Cole, I. D., West Virginia.
 Conn, Clyde W., Pennsylvania.
 Coughlan, John S., West Virginia.
 Coogle, W. L., West Virginia.
 Cross, Earl W., Pennsylvania.
 Creighton, Lawrence C., Pennsylvania.
 Davis, George B., Pennsylvania.
 Dunham, Robert W., West Virginia.
 Disbrow, Edward P., Connecticut.
 Evans, George P., Pennsylvania.
 Farag, Mikhail, Egypt.
 Francis, Thomas R., Pennsylvania.
 Fisher, Jacob, New Jersey.
 Griffith, Wilbert E., Pennsylvania.
 Gorman, John J., Massachusetts.
 Haynes, H. H., West Virginia.
 Hanson, A. N., Utah.
 Higgins, T. F., New Jersey.
 Haines, C. N., Pennsylvania.
 Jones, Latimer P., West Virginia.
 Johnson, G. D., West Virginia.
 Johnson, H. W., Maine.
 King, Nicholas J., Massachusetts.
 Leahy, John T., Connecticut.
 Lamy, Anthony W., New Jersey.
 Miller, William M., Maryland.
 Morrow, Hugh, Florida.
 Miles, Charles G., Massachusetts.
 Morgan, Charles G., West Virginia.
 McCutcheon, Merle, West Virginia.
 Nolte, Albert E., West Virginia.
 Owens, W. T., West Virginia.
 Onnen, J. G., Maryland.
 O'Malley, John J., Pennsylvania.
 Petros, J. A., Persia.
 Pratt, Ivan E., New York.
 Pickering, J. Everett, Massachusetts.
 Robinson, Mose, New Jersey.
 Ryan, Edwd. J., New Brunswick.
 Stone, M. R., West Virginia.
 Stuart, L. C., New York.
 Steenbergen, J. H., West Virginia.
 Sweeney, H. Wilson, Maryland.
 Scanlan, Thos. F., Rhode Island.
 Strauss, Geo. A., Maryland.
 Stevenson, T. Wm., Utah.
 Salmon, W. J. G., Pennsylvania.
 Stevens, Rush B., New York.
 Strobel, Walter G., Pennsylvania.
 Summers, E. J., West Virginia.
 Tarter, W. W., Virginia.
 Thearle, Wm. H., Maryland.
 Wise, Geo. A., Pennsylvania.
 Wilson, Harry C., Pennsylvania.
 Whitaker, P. W., Maine.
 Whisler, Horace A., West Virginia.
 Whipple, E. E., New York.
 Walker, Wm. J., West Virginia.

The College prizes were awarded by Prof. William Simon to the following:

- W. H. Thearle, M. D., Maryland, First Prize.....Gold Medal.
 A. N. Hanson, M. D., Utah, Second PrizeGold Medal.
 Thos. F. Scanlan, M. D., Rhode Island, Third Prize.....Gold Medal.
 Jno. J. O'Malley, M. D., Pennsylvania, Fourth Prize.....Gold Medal.

Those who received honorable mention were:

- C. R. Bancroft, M. D., New York. Rush B. Stevens, M. D., New York.
 H. H. Haynes, M. D., West Virginia. T. Wm. Stevenson, M. D., Utah.
 Geo. B. Davis, M. D., Pennsylvania. S. C. Austin, M. D., West Virginia.
 H. W. Johnson, M. D., Maine. Geo. A. Strauss, M. D., Maryland.
 W. T. Owens, M. D., West Virginia. F. Roman Wise, M. D., Pennsylvania.

The following received hospital appointments:

RESIDENT PATHOLOGIST, CITY HOSPITAL,
 Rush B. Stevens, M. D.

HOSPITAL APPOINTMENTS CITY HOSPITAL:

Wm. J. Schmitz, M. D.....	Resident Physician.
A. M. Sorrell, M. D.....	Associate Resident in Surgery.
	Associate Resident in Medicine.
Geo. A. Strauss, M. D.....	Assistant in Gynecology.
H. H. Haynes, M. D.....	Assistant Resident Physician.
Latimer P. Jones, M. D.....	" " "
John J. O'Malley, M. D.....	" " "
J. A. Petros, M. D.....	" " "
M. R. Stone, M. D.....	" " "
W. W. Tarter, M. D.....	" " "
Wm. H. Thearle, M. D.....	" " "

MATERNITE HOSPITAL,
J. H. Steenberg, M. D.

BAY VIEW HOSPITAL:

H. H. Esker, M. D.....	Resident Physician.
Joseph G. Graver, M. D.....	Assistant Resident Physician.
Clyde W. Conn, M. D.....	" " "
H. Wilson Sweeney, M. D.....	" " "

Dr. Charles F. Bevan announced the following changes in the faculty:

Dr. J. W. Chambers.....	Professor of Principles and Practice of Surgery.
Dr. Charles F. Blake.....	Professor of Operative Surgery and Clinical Professor of Diseases of the Rectum.
Dr. Archibald C. Harrison.....	Professor of Anatomy and Clinical Surgery to succeed Dr. Isaac R. Trimble lately deceased.

The Alumni Banquet was held at the Hotel Belvedere after the commencement exercises.

The Executive Committee deserve credit for their efforts.

The menu and service were excellent.

Dr. Geo. W. Mitchell, as toastmaster, introduced the speakers. His humor, as is characteristic of Dr. Mitchell, was lightly tinged with sarcasm.

Mayor Mahool appreciated the advantage to Baltimore of its many medical schools, and congratulated the College upon its past and present successes. He expressed his satisfaction in the general excellence of our College, its faculty and graduates, and encouraged us to continue our efforts in the future for a better and higher medical education.

Dr. J. W. Chambers said many happy things about the faculties past and present. Dr. C. G. Morgan addressed the valedictory to the class of

'08 in excellent manner. Dr. Wm. R. Howard, of '79, compared '79 with '08, much to the advantage of the present. Dr. R. E. Lee Hall represented the Alumni Association in his forcible and entertaining manner, and closed his remarks by reciting some original stanzas, reviewing the faculty of '84. Dr. Britton D. Evans responded to the call of the toastmaster, and despite the lateness of the hour held the attention of his listeners by a most entertaining discourse, partly serious and partly humorous.

Dr. Geo. A. Strauss, '83, then raised his voice in song, and with the tuneful melody of Auld Lang Syne the class exercises of 1908 were closed.

The officers of the Alumni Association are:

Dr. Britton B. Evans, President; Dr. H. H. Esker, First Vice-President; Dr. H. J. Jarrett, Second Vice-President; Dr. W. M. Garrison, Secretary; Dr. Charles Emil Brack, Treasurer. Executive Committee: Dr. Standish McCleary, Chairman, Dr. H. M. Cohen, Dr. James H. Hartman.

REUNION OF THE CLASS OF '79.

One year ago, Dr. Geo. H. P. Cole, of Roanoke, Va., began to interest himself in a reunion of his class, and with the assistance of the JOURNAL and by dint of hard work and extensive correspondence finally located definitely 46 living members. He was also able to establish the obituary record of 34 members.

A committee consisting of Dr. Lewis A. Griffith, Dr. Jos. H. Branham, and Dr. Cole concluded the arrangements and made a program for the occasion. Nineteen members arrived at headquarters at the New Carrollton during the day on Monday, June 1. It was both interesting and touching to note as each classmate made his appearance how those already on the field endeavored to recall the features and personal characteristics of men, whom some had not seen since the day of graduation 29 years ago. Some were easily recognized and others were mistaken for some other member of the class. What appealed to one most was the well-preserved and prosperous appearance and the almost boyish jollity and enthusiasm with which each and every one entered into the spirit of this class reunion.

An executive session was held at headquarters at 7 p. m. for the purpose of permanent organization. Dr. J. A. Horne presided with Dr. Wm. R. Howard acting as secretary. Dr. Geo. H. P. Cole's efforts in arrang-

ing the meeting were acknowledged by a vote of thanks. The meeting expressed its appreciation of the assistance of the JOURNAL by a like vote to Dr. Brack. Upon unanimous agreement permanent organization was established. Dr. J. E. Rigg, of Wilkinsburg, Pa., was elected president; Dr. J. H. Branham, of Baltimore, vice-president, and Dr. Geo. H. P. Cole, secretary and treasurer. It was further agreed that a reunion of of the class be held every five years. Dr. Brack offered the services of the JOURNAL for the purpose of keeping in touch with the members and publishing whatever might be of interest to them.

At 9 o'clock the meeting adjourned to the banquet hall where a flash-light picture was taken. Dr. Griffith officiated as toastmaster. Drs. Chas. F. Bevan, John W. Chambers, and Chas. E. Brack were invited guests of the occasion.

At the conclusion of the service Dr. Griffith read the list of the deceased members and a standing toast was drunk to the memory of the departed.

Dr. Bevan then responded to the call of the toastmaster. Dr. Bevan is the only living member of the faculty of our College in 1879 who is still actively connected with the College. Dr. Opie has retired from active practice and active college association. Dr. Bevan was moved to tears when he recalled the days of '79 and brought up the memories of his associates in the faculty at that time—of Howard; of Erich, a genius; Brown, perhaps the most gifted; of Gundry, whom he designated as the most lovable; of Coskery and Lynch, men of advanced ideas and especially gifted; of Rohe, the best comrade, loyal and genial; of Friedewald, a man among men; of Latimer, quiet, bold, beloved by all who knew him to his end.

Those who are now at the helm continued to keep up the work so well begun 29 years ago, encouraged by the memory of those gone before, who have left their footprints in the sands of time.

Dr. Branham recalled the two sessions of five months compared with the four sessions of eight months to-day. Dr. J. M. Cain, the only bachelor of the class, aroused much amusement by stating that he was ready now to become a benedict if the lady were selected for him.

Drs. Alva L. Chapman, Edwin R. Dodson, J. Thomas Hall, and Dr. Cole expressed their delight and satisfaction in being present. Dr. Cole

said that he had been looking forward to this occasion for a year and regretted having missed the opportunity of a reunion years ago.

Dr. Chambers, in his happy vein, addressed the assembly as freshmen. The men had not changed as much as medicine, which was absolutely a new profession. He said among other things decidedly Chamberesque: "If you knew all that was known twenty-nine years ago you would not pass from the freshmen class to-day."

Dr. J. A. Horne dwelt upon the necessity of growth and further development after graduation, of the importance of recognizing the value of new things as they came up and of adopting the good. In the 80's a man who entertained the germ theory was thought to be cracked. He spoke of the admission of the coal-tar products and anti-toxins into therapeutics and their ready adoption.

Dr. Wm. R. Howard was glad to hear again the soft southern accent and enjoy our warm-hearted hospitality. When he was resident at the hospital he saw performed one laparotomy. When the abdomen was opened a tumor the size of a squash was disclosed and the abdomen at once sewed up again. He mentioned that Dr. Chambers blew into Rochester once in a while and talked some nonsense sprinkled with sense.

Dr. Jno. J. Jones related his extensive travels. Dr. Chambers wanted to know when he had last been in Mars. Dr. Jones advised the doctors to travel early, not to put it off until more convenient. A proper rest and vacation means good health and better capacity for work. One can do better work in ten months than in twelve.

Dr. Thomas W. Kay reviewed the class as he knew it in '79. They came from all classes and conditions, and greatly varied as to physical and mental attributes. He estimated the amount of work done by the class in 29 years; of the multitude ushered out and ushered into the world. He told the story of the old darkey mixed up in a case of illicit distilling, who was not familiar with the Joshua who made the sun stand still, but knew the Joshua who made the moon-shine.

Dr. Jos. H. Leib remembered only three familiar faces. He had been closely associated with Dr. Ramsey, his chum, ever since graduation.

Dr. Chas. L. Morgan found the faces of his old associates unfamiliar; he tried to recall features as they were in his mind's eye. They were like dust-covered portraits. Brushing away the dust gradually disclosed fa-

miliar features; so closer observation brought out the features long remembered and recognized. He recalled the street cars drawn by mules with little bells on them, the gas jets and kerosene lamps in '79. The giant strides in the city were paralleled by the improvements in medicine.

Drs. Raphael Painter, John P. Parrott, D. T. Ramsey reminisced, the latter thought Dr. Bevan had found the elixir of youth. Reunions, he thought, had a beneficial effect upon their patients; it gave them an opportunity to get well.

Dr. J. Edwin Rigg said that their time of graduation was the beginning of a new era in medicine. They had to disregard much of what had been taught to take up new things. A too scientific trend in medicine had in it a danger in the disregard of clinical signs and a too great dependence in laboratory tests.

Dr. Winchester had come 600 miles to meet a lot of strangers; he found no strangers present now.

Drs. Clarence W. Webb and Calvin K. Young expressed their pleasure in the meeting and their anticipation of future reunions under equally pleasant conditions. Auld Lang Syne and mutual felicitations closed the meeting.

THE CLASS SONG OF '79.

The class song of '79, the author of which we unfortunately do not know, has been preserved by Dr. Griffith, and we reprint it as it was read at the recent reunion.

I know full well this form of mine
Is but a nomad cell,
And pabulum and blastoderm
Within each tissue swell,
But while my heart and nerves and lungs
Are subject to my brain,
Each pulse will thrill, each nerve impart
My love for Mary Jane.

CHORUS:

My darling Mary Jane,
My Mary Jane so true,
I die a death with every breath
I draw when far from you.

Let Lynch praise, prate and vindicate
Verat. Vird. good and strong,
While Gundry still on quinine pill
Extols both loud and long
And Opie, the ladies' favorite,
Describes each pelvic plane,
While I am here my thoughts are there
Where dwells my Mary Jane.—CHO.

Coskery with his trenchant knife
Can cut with steady hand,
And Bevan entertains the class
With his quotations grand,
But ready knife and brilliant phrase
Bring naught to me but pain,
While I am far away from home
And from my Mary Jane.—CHO.

Let Arnold with his neurolem
And talk of rheophore,
Latimer slays from day to day
Of canines half a score,
Chambers with his silver thread
Ligates each portal vein,
My thoughts still turn in dreamy muse
To my sweet Mary Jane.—CHO.

And Erich with his hand so bold
The friend of Baby Mine,
And Rohé so mild and gentle
Hygiene he will define,
And Friedenwald the cataract
Graphically explain,
While I am far away from home
And my sweet Mary Jane.—CHO.

Let Sal Rochelle and Sal Prunelle,
With other sirens burn,
While I of Simon's cupric salts
And acids strive to learn,
But when with my sheepskin in my hand
I leave old Galen's fane,
I'll spend less nights with phlebolites,
And more with Mary Jane.—CHO.

THE CLASS PICTURE OF '79.

The members of the class of '79 will be pleased to know that the flash-light picture has turned out very well indeed. Those members who wish to secure copies can do so by ordering them from Bachrach Brothers, Baltimore. Price, \$1.50 each.

CLASS REUNIONS.

The successful reunion of the class of '79 has encouraged other classes to arrange a meeting to be held in 1909 at the time of our next commencement. '84 will celebrate its twenty-fifth birthday and '04 its fifth anniversary.

Dr. R. E. Lee Hall will stand sponsor for '84, and all communications should be addressed to him at 218 Law Bldg., Baltimore.

Dr. A. C. Gillis will represent the class of '04, and communications will reach him at 1519 N. Caroline St., Baltimore.

It is desirable that those who contemplate taking part in the exercises should write at once so that proper arrangements can be made as early as possible.

We append a list of both classes representing those members whom we have not been able to locate, and request our alumni to furnish us with information regarding them.

Members of the class of '85 who are interested in the reunion will communicate with Dr. Britton D. Evans, Graystone Park, New Jersey.

The class of '84 expect to have a reunion at the College Commencement and Banquet in June, 1909. The Commencement will be held immediately preceding the Atlantic City meeting of the American Medical Association, so that those who wish to do so may attend both meetings. All the members of the class of '84 who expect to be present will communicate at once with Dr. R. E. Lee Hall, 18 E. Lexington St., or Dr. C. E. Brack, 500 E. 20th St., Baltimore, Md.

Information is desired about the following members of '84. A copy of the catalogue or commencement program of this year would be greatly appreciated and returned if so desired. A. T. Cooper, L. H. Johnson, Carl M. Kelly, Hosea P. Murray, W. A. L. Riegel, P. Robinson, F. E. Robinson, J. B. Showalter, M. B. Webb, C. O. Mathews.

The following list of members of '04 is presented for information: C. Aursleff, Fer S. Ball, Albert Haskins, B. C. McNeil, Jno. J. O'Donnell, H. M. Rauch, T. N. Saltz, Thos. Sage, MacDougal, B. F. Morris, A. J. McNeil, S. H. Wertz, C. A. King, J. F. Hennessy, L. B. Evans.

 THE ALUMNI ASSOCIATION MEETING.

The Alumni Meeting was held on Tuesday night in the College Building. Dr. Britton D. Evans, the president, presided and opened the exer-

cises by an appropriate address in which he advocated strongly the necessity of proper representation of the medical profession by the appointment of a physician in the President's cabinet.

Nominations for officers were then asked for. Dr. Chambers nominated Dr. Wm. R. Howard, of Rochester, of '79, for president. Nominations were closed and Dr. Howard unanimously elected. Dr. H. H. Esker was elected 1st vice-president; Dr. Geo. H. P. Cole, of Roanoke, Va.; 2d vice-president; Dr. W. H. Thearle, '08, 3d vice-president; Dr. J. H. Hartman, secretary; Dr. Jno. N. Chambers, assistant-secretary; Dr. Chas. E. Brack, treasurer.

Dr. Howard accepted his election in a graceful speech, following which Dr. Robert E. Lee Hall, in a humorous manner, recalled his advent to the city and to the College. Dr. Hall promised to organize the class of '84 and have a reunion of this class in 1909. Dr. Evans then introduced Dr. Brack, who delivered the annual address to the Alumni Association. After welcoming the visiting alumni, congratulating the faculty upon its success and the graduating class upon its achievements, Dr. Brack briefly reviewed the development of obstetrics. He dwelled upon the better care of the parturient woman, the more extensive repair of injuries to the parturient canal, the better protection of the woman from the consequences of labor and the proper care in the early management of the new-born child. He advocated the instruction and licensing of the non-graduate nurse. A growing tendency to commercialism in medicine was strongly deprecated and the class of '08 strongly advised to take an active interest in matters of professional organization. The young doctor should early affiliate himself with the local medical society and early become a member of the American Medical Association and take an active interest in their proceedings and help to advance the profession and its interests.

The class of '08 was then as a body elected to membership in the Alumni Association. The meeting adjourned to partake of refreshments, which had been provided in the lower lecture halls.

A. M. A. MEETING, CHICAGO.

ALUMNI C. OF P. AND S. NOTES.

By S. W. WOODYARD, '91, GREENEVILLE, TENN.

The attendance of our alumni at the Chicago meeting of the American Medical Association was quite gratifying, though the number was not so

large as at Boston or Atlantic City. This was due to the large percentage of our men residing in the east.

Tuesday evening being designated by the committee of arrangements for "general alumni reunions," the following met at the "Tom Jones Cafe," where an informal dinner of eight courses was served: Drs. Hugh F. Cook, '96, Newark, N. J.; W. S. Alexander, '93, Oxford, Ohio; J. E. Sawtell, '86, Kansas City, Mo.; H. M. Orr, '95, LaSalle, Ind.; S. W. Woodyard, '91, Greeneville, Tenn.; B. C. Keister, '82, Roanoke, Va.; M. E. Silver, '97, Detroit, Mich.; J. M. Scanland, '97, Warm Springs, Mont.; Robt. L. Stokes, '03, Butte, Mont.; A. C. Biddle, '03, Butte, Mont.; T. J. Cummins, '03, Plattsburg, N. Y.; A. Samuels, '98, Baltimore, Md.; L. F. Ankrum, '86, Pittsburg, Pa.; Philip S. Chancellor, '01, Chicago, Ill.

Those present enjoyed the occasion to the utmost and a vote of thanks was extended Dr. Chancellor for his uniform courtesy.

Dr. Reid Hunt, '96, Washington, D. C., was elected chairman of the Section on Pharmacology and Therapeutics.

Drs. Harry Friedenwald, '86, Baltimore, J. E. Sawtell, '86, Kansas City, Kan., and S. W. Woodyard, '91, Greeneville, Tenn., were members of the House of Delegates, the business body of the Association.

We notice the names of the following in the registration list, though did not have the pleasure of meeting them: Drs. H. P. Jack, Sherman Voorhees, W. P. Spratling, G. Kirby Collier, J. B. Boucher, Sam'l F. Darling, and J. B. McElroy.

The next meeting of the Association will be in Atlantic City, and as usual when the meeting is in the east, there will be a large number of our men present, and arrangements should be made for a general reunion. A larger number can be gotten together there than elsewhere if the right effort is made. Some special hotel, the Islesworth for instance, should be selected as headquarters and publicity given to the matter in the January and April issues of the ALUMNI JOURNAL.

COMMENCEMENT EXERCISES CITY HOSPITAL, 1908.

The Seventh Annual Commencement of the Baltimore City Hospital Training School for Nurses took place Tuesday evening, June 23, at 8 o'clock p. m., the College Amphitheatre being artistically decorated with

the Training School colors for the occasion. Diplomas were awarded to ten young ladies who have completed the prescribed term of three years.

After the opening prayer by the Rev. T. B. Hughes, the chaplain of the hospital, the dean of the faculty, Dr. C. F. Bevan, made a few comments on the nursing profession, when he introduced the Rev. John D. Boland, who further encouraged the nurses in the great duties they have undertaken for the aid of suffering humanity. Many actions of various natures and under strange circumstances, he told them, would they have to perform, but their great success would depend on the inspiring motive with which these actions would have begun.

The diplomas were then awarded by Dr. Bevan, dean, who referred to the absence of Miss M. Louise Bright, of Maryland, on account of illness, hoping that her abode in the salubrious climate, she is enjoying, may eventually restore her to health. The other young ladies receiving diplomas were: Misses Selma Gibson, Maryland; Maria del Pilar Cabrera, Porto Rico; Mary Teresa Ruppert, Maryland; Sara Waples Crosley, Maryland; Elizabeth Julia Russell, Maryland; Sadie F. Dorsey, Maryland; Rose A. Tracey, Pennsylvania; Alice Sheridan, Maryland; Mattie Caton, Maryland.

The medal for practical nursing or for the most efficient work and deportment during the entire scholastic period, was awarded to Miss Cabrera, Porto Rico.

Dr. C. Hampson Jones, assistant health commissioner, was then introduced, who congratulated the trained nurses on their field of noble work, giving a history of nursing and telling how much had been done by the great women who founded the nursing profession for the benefit of the sick and for the advancing of methods in medical and surgical practice. He advised the nurse on her duty to the whole public, putting great stress on the instruction, by them, of mothers in the prevention of contagion, etc., forcefully picturing how death may be avoided by these preventive means.

The next day the alumnae of the Training School met. The new graduates were proposed as members, and Miss Eleanor Parker, R. N., 1903, was again elected president; Miss Sadie A. Roe, R. N., vice-president; Miss J. Tuve, R. N., secretary, and Mrs. Nicholls, R. N., treasurer. In the evening an address was given by Miss Parsons, superintendent of nurses at the Sheppard and Enoch Pratt Hospital, advising the new

recruits to the nursing profession to strive always to advance their chosen work by their own individual interest in all pertaining to it, and to strengthen the State Association of Registered Nurses by becoming members.

Obituary.

DR. JAMES T. MARTIN, '79, died at his home in Mendota, Va., April 3, from cerebral hemorrhage, aged 63.

DR. WILLIAM H. BAGWELL, '83, a member of the Medical Society of the State of North Carolina and the Pitt County Medical Society, died at his home in Greenville, April 7, after an illness of only a few days, aged 44.

DR. JOHN C. F. BUSH, '84, of Wahoo, Neb., a member of the American Medical Association and Medical Society of the Missouri Valley, district surgeon of the Union Pacific Railway, and local surgeon for the Chicago & Northwestern System, died June 4, in Warren, Pa., where he had gone en route to Europe, aged 51.

DR. MILLARD F. REED, '82, a member of the Kentucky State Medical Association and president of the Lee County Medical Society, health officer of Lee County and medical referee of the State Board of Health since, 1884, and one of the most efficient practitioners of the mountain district of Kentucky, died at his home in Beattyville, March 23, after an illness of several weeks, aged 50.

DR. THOMAS FRANCIS STANTON, '96, died at his home in Bridgeport, Conn., May 8, 1908. Death followed an operation for appendicitis. He was born at Hartford in 1864, and at the age of 19 went to California where he remained for several years. Later he returned east and in 1896 began the practice of medicine. He was numbered among the most successful of the Bridgeport physicians. He was a 32d degree Mason, member of the order of the Sons of St. George, and of numerous other societies.

Personal Notes.

DR. CHARLES B. SMITH, of Washington, has been elected mayor of the borough of Washington.

DR. E. A. BOWERMAN, '95, of Buffalo, New York, has been elected president of the Buffalo Academy of Medicine.

DR. A. W. VANKIRK, '07, passed the Washington State Examining Board at Spokane and will practice in that State.

DR. X. Y. SMITH, '04, and DR. W. S. LASLIE, '04, have been spending the spring in Vienna, pursuing their medical studies.

THE Executive Committee for the following year consists of Dr. George H. Hartman, chairman; Dr. A. C. Gillis and Dr. W. L. Nicholls.

DR. JULIUS FRIEDENWALD, '90, Professor of Diseases of the Stomach, has been elected president of the American Gastro-Enterological Society.

DR. C. F. KEYSER, '86, has been located in Duquesne, Pa., for over twenty years, and is considered one of the most prominent practitioners in that city.

DR. W. S. FORD, '94, of Chester, Nova Scotia, spent the winter in southern California and part of the month of May about the College in Baltimore. He has returned to resume his practice.

Marriages.

DR. C. W. JOHNSTONE was married to MISS BELLE McLANE, Baltimore, Wednesday, July 1.

DR. T. H. WERTZ, '04, was married to MISS ERMA GRACE TRACY, the daughter of Mrs. Theodore Tracy, of Lineboro, Md., June 16, 1908.

DR. PAUL TRAYWICK was married to MISS JENNY CRUTE GARNETT, the daughter of Mr. and Mrs. William E. Garnett, of Curdsville, Va., June 24, 1908.

Correspondence.

SONYEA, N. Y., June 22, 1908.

My Dear Doctor Brack.—I am pleased to enclose with this my check for \$3 in payment of the JOURNAL of the Alumni Association of the College of Physicians and Surgeons for a period of three years.

Although the JOURNAL does not come to my desk very frequently it is always a welcome visitor when it does come. It is always a pleasure to learn from the JOURNAL much that is going on at the old College in Baltimore.

With best wishes.

Cordially yours,

W. P. SPRATLING.

DARWIN, TEX., April 9, 1908.

Dear Doctor Brack.—Enclosed you will find M. O. for two dollars (\$2), for the JOURNAL of the Alumni Association for 1907 and 1908.

I am surgeon of the Cannel Coal Co., and am doing very well. As most of the miners are Mexicans, a knowledge of Spanish is essential, but I experienced little difficulty in readily learning to speak the language well enough for all practical purposes. I frequently cross the Rio Grande to make professional visits in Mexico, and have had some very amusing experiences in the Land of Mañana. With best wishes.

Fraternally yours,

W. M. CLUNE, '96.

NOAN, LA., May 16, 1908.

Dear Doctor Brack.—Enclose to you check for \$2 to cover two years' subscription to the JOURNAL. I receive the JOURNAL regularly and with pleasant memories. Greatly regretted to notice the death of Dr. Walls, '96, my class, a true and noble man, and Bob Latimer has also passed away—certainly a great practitioner of medicine and a man; and also young Dr. Kerle. One by one our time approaches. Regards to Dr. Gardner, and with best wishes for the JOURNAL and C. P. & S.

Yours fraternally,

S. E. PRINCE.

NEW YORK, May 14, 1908.

Dear Dr. Brack.—I am enclosing you herewith my subscription renewal and check for \$1 for year ending April, 1909.

For several years I have worked on producing a Raw Milk in a dry state that should be pure, and that would keep. I am pleased to tell you that the above company, of which I am the consulting chemist, is manufacturing the flour and with those two qualities chief among many others.

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Yours very truly,

G. H. ROCHELLE.

WAR EAGLE, W. VA., June 20, 1908.

Dear Doctor Brack.—Please find enclosed check for \$2 for JOURNAL.

I left the Welch Hospital April 1 and located at the above place, and am now doing Coal Camp practice. I have between 800 and 1000 men on the list, besides a good country practice.

I was very much grieved to learn of the deaths of Drs. Trimble and Keirle. While I know it was quite a shock to the P. & S., it is good to know they have others who can take up their work and go ahead.

With best wishes for everyone connected with the P. & S., I am,

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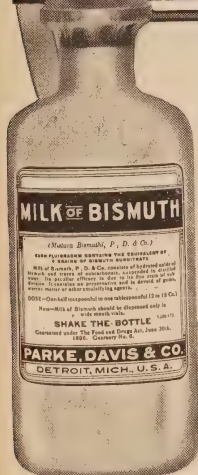
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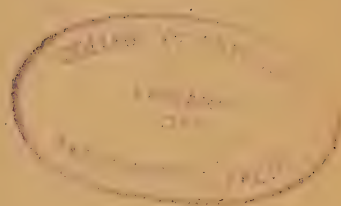
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Vol. XI

No. 3

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THE ADDRESS AT THE OPENING OF THE COLLEGE FOR
THE THIRTY-EIGHTH SESSION.

BY DR. A. C. HARRISON.

My friends, it is a privilege indeed to have the honor of addressing so sagacious an audience as this, and save for my fears of shortcomings, I might say with truth that it is with great pleasure that I am permitted to greet and welcome these classes of the College of Physicians and Surgeons to-night. For the lack of quality in my talk, I promise you the saving grace of brevity. To each of you we extend a hearty welcome, and the assurance of our constant interest in your welfare. There will be some among you who are new to us, and to whom the workings of a medical college and the mysteries of medicine are new, and perhaps discouraging. To these I can promise that a closer acquaintance will dispel their misgivings, and if there be some among you who do not know what you want, just ask Dr. Bevan for it, and he will promise it to you.

The advantages that the present-day medical student has over those that have gone before are many. So many things that a few years ago were considered great accomplishments, are now but the every-day knowledge of the average medical graduate. He who is diligent, and endowed with an average mind, will find himself at graduation the possessor of more technical knowledge than was to be had by the average medical man of a generation ago, in a whole life time. Though it is not true of the individual, I believe it is true of the average medical student of to-day, that he is a better man when he begins than those of former years. I do not mean that he is made primarily of better clay, for that would indeed

be most untrue, but that his advantages of education and training have been far superior. With these increased advantages, however, has come a proportionate increase in what is demanded of him. Medicine has grown to be, perhaps, the most liberal of all professions, and demands of its devotees a wider range of learning, and more constant application than any other. Indeed, there is no branch of knowledge that does not have its place somewhere in the great medical structure. Our program of studies is constantly on the increase, and the required standard is constantly rising. Likewise, the time required to be spent in the pursuit of these studies has rapidly increased until now all colleges worthy the name are on a four-year basis, and this college, along with some of the more advanced ones, is contemplating the addition of an optional fifth-year for those who wish to perfect themselves more completely in the clinical branches. On the other hand, along with this higher standard in the quality of the student, and the greater knowledge demanded of him, comes a corresponding increase in the opportunities demanded for him. Constant increase in laboratories, and laboratory supplies, and an ever-increasing demand for more and better teaching, until now it requires a small army of teachers specially equipped to supply his needs. In a class of medical students there will be found many types. Some are gifted by nature with brilliant minds, and by opportunity with good preparation; others with less of either; and others again gifted only with an inborn and well-cultivated indolence. But the race is not always to the swift, nor the battle to the strong. Industry, determination, and fidelity largely equalize the differences in types. The man of average intelligence, who possesses these three elements of character, is the one most sure to reach the goal, and is usually in better condition and better balanced when the race is run, than his more brilliant competitor who lacks any one of them. Elbert Hubbard says, "Many men will do things fairly well if fathered by some one, and constantly patted on the back, but give me the man who can, and will do things in spite of hell." Victory in some measure invariably comes to the man who keeps constantly in training, but this process of keeping always in training is a very trying one, and may seem at times to offer little else than bitter disappointment. But it should be sufficient inspiration, and compensation, too, if you can know that when your opportunity does come, you will be caught "with the goods on

you." The great achievements in medical science have been accomplished not by men of exceptional brilliancy of mind, but by men of average mind and indefatigable industry. The greatest monument to medical industry, in all its history, is the life-work of John Hunter, some of whose characteristics and achievements I trust may interest you. He was born of good parents at Long Calderwood, a small estate about seven miles from Glasgow in the year 1728. He was the last of ten children, greatly indulged by his mother, and had an utter distaste for books. Throughout his childhood two characteristics stood out clearly; this hatred of all book lore, which he steadfastly refused to follow, and an ardent love for nature, in the pursuit of which he spent his time rambling about the woods and fields. Indeed, these characteristics are to be seen running uppermost throughout all his life and works. As a boy he was good at such games as the village afforded, but deficient in self-control, idle and ignorant; a great disgrace to a Scots' boy living within walking distance of Glasgow College, his father a gentleman, and his brothers were studying medicine and law. Thus, he spent his boyhood in dreaming, watching the clouds and the grasses, the bees and the birds, wondering why the leaves changed color in the autumn, and as he said of himself, "pestering everyone with innumerable questions about things that no one knew or seemed to care." At last when he was nearly twenty he seemed to come to himself, the great city began to call to him irresistibly, and he made haste to join his already famous brother in London. Immediately a marvelous change seems to have come over him. He began work as a dissector in the new, but small, anatomic school established by his brother, and performed this work with great avidity. In the three following years he laid the foundation of his power over anatomy, and saw something of the hospital practice of Cheselden and Pott. He did not work in anatomy, as is usually done, for a few hours a day, but was employed at it from the rising to the setting of the sun. Within the year he became demonstrator to the students, and held in his hands the honor of the new school, so recently founded. Here he seems to have been in his element, hobnobbing with the resurrectionists at night and working all day in the unwholesome air, dissecting, demonstrating, and putting up specimens. He continued to pursue this ruling passion of his life with feverish energy, and was not content with the human body alone, but soon sought

means to obtain every manner of animal, fish, and fowl, and analyzing their anatomic elements with equal ardor. Thus began the building of that marvelous collection known as the Hunterian Museum, in which can be found to this day many dissections unsurpassed for beauty and perfection, standing as mute witnesses to a life of industry, and accuracy. He read but little, and cared nothing about what others might be doing. Aside from his incessant industry, and quick comprehension of facts, his most striking characteristic was his method, most clearly expressed in his oft-quoted saying, "Don't think; try, be patient, be accurate." Through the succeeding years, he applied these methods with great fidelity, investigating, experimenting, analyzing, and collecting, pushing his work with an intensity that seemed beyond physical endurance. Anatomy, physiology, and pathology, that was his work, and the application of the innumerable facts he gleaned from these sources to practical surgery was his recreation. Here, indeed, was a man who kept himself constantly in training, and for his reward reaped a harvest unsurpassed in abundance, and lasting fame. It appears that during the first twenty years of his medical career he paid but little attention to the actual practice of surgery, nor did he seem to care for it; but in the year 1768 he was elected one of the surgeons to St. George's Hospital. This election was of infinite value to him. It has been said that a surgeon without a hospital is like a gardener without a garden. Now at last he had his garden, and he made it bear fruit an hundred-fold. It gave him an opportunity to put into practice his vast store of knowledge. His superiority over all competitors brought him as clientele not only the multitudes, but the crowned heads of Europe as well. Here was his opportunity, and when it came it found him "with the goods on him." One would suppose that attention to this large clientele would have greatly curtailed his work of investigation, but not so with John Hunter. What time he spent in attention to his practice he filched again from his sleeping hours, and could regularly be found in his laboratories by four in the morning, and rarely retired before midnight. Thus, we might continue to paint the picture of this wonderful man, but it is impossible to include in one view, the multitudinous forms of his work. He was anatomist, biologist, naturalist, physician, surgeon, pathologist, all at once and all in the highest; and the secret of it all was his indefatigable industry. In the

very nature of things, however, the machine must weaken somewhere when kept constantly under such high-pressure action, and in Hunter's case it showed itself in the most characteristic form, angina pectoris. He was sorely tried by this disease in the later years of his life, but even this could not deter him from his labors. He was wont to say, that his life was at the mercy of any fool who chose to vex him, and he died in actual harness under these very circumstances. During an acrimonious debate before the Board of St. George's Hospital, he was seized with his final attack, and thus ended the most marvelous life in medical annals. So well did he build, and so far afield did he reach, that but little of moment was added, save by Jenner alone, from the time of Hunter to the time of Virchow, Pasteur, and Lister.

And now in closing let me quote to you the words of Jonathan Hutchinson, used on a similar occasion: "Finally, gentleman, permit me to commend to you these formulæ; prize strength, love the beautiful, practice self-denial, and be patient." For my own part, I trust that every man of you may attain his highest ambition in this school, and in after life reap an abundant reward.

AN EPIDEMIC PNEUMOCOCCIC CATARRHAL DISEASE.*

CLINICAL STUDY.

By DR. HARVEY G. BECK.

BACTERIOLOGIC STUDY.

By DR. WILLIAM ROYAL STOKES, BALTIMORE, MD.

CLINICAL STUDY.

INTRODUCTORY.

It may appear presumptuous to insert the word "pneumococcic" in the title of a paper which has to deal largely with a disease or condition with local manifestations involving the mucous membrane of the upper air passages and conjunctivæ, because recent investigations tend to show that these anatomic situations are a normal habitat of the pneumococcus. It is, therefore, with a considerable degree of reserve that this title has

* Reprinted from the Journal of the American Medical Association.

been adopted, even after coupling a definite clinical picture with the persistent presence of an overwhelming number of pneumococci characterizing this series of cases. It is, of course, impossible to make a numerical division as to what constitutes a normal or an abnormal invasion of pneumococci in the mucous membrane of the eye, nose, and throat. Therefore, we do not regard the increase in the number of these organisms, even though it be enormous, of sufficient importance to warrant our conclusions, but when this is associated with a definite underlying pathologic basis and distinct clinical features we feel justified in reporting this series of cases under this caption.

REVIEW OF LITERATURE.

In a cursory review of the literature we find that epidemic pneumococcic conjunctivitis has been described in a special article by Axenfeld.¹ We also find a description of pneumococcic fibrinous pharyngitis by Bissell, and pneumococcic pseudomembranous bronchitis by Landrieux and Triboulet.² If the conditions these observers described correspond with our present epidemic then they failed to comprehend the entire clinical picture and merely presented single aspects of the disease.

Davis of Chicago³ intimates that acute catarrhal conditions resembling gripe might possibly be caused by the pneumococcus, but does not furnish clinical and bacteriologic proof of the assumption.

Samuel J. Darling, pathologist, Ancon Hospital, Panama,⁴ examined the accessory nasal sinuses in thirty-seven autopsies in which death was due to pneumococcus infection. Ninety-two per cent of the cadavers showed involvement of one or more of these sinuses. Thirteen cases of pneumococcus meningitis were studied. All of these cadavers presented an inflammation of the sinuses, and in every one the middle ear and mastoid were normal. The inflammation was usually intense, fibrino-purulent in character, and apparently antedated the general infection. In all of his cases the pneumococci were found in abundance. He also found a pneumococcus sinusitis in 28 per cent of the control cases in none of which death was due to pneumococcus infection.

Darling believes that the portal of entry of the pneumococcus is in most instances an accessory nasal sinus, the mucous membrane in the sinus becoming infected through a previous rhinitis.

I mention these investigations of Darling's because his observations and the study of our cases establish the fact that there is undoubtedly a direct line of invasion by the pneumococcus beginning in the upper air passages, frequently involving the accessory sinuses which may ultimately lead to the development of pneumonia, pneumococcus meningitis, endocarditis, septicemia, etc.

STUDY OF EPIDEMIC.

Two years ago this spring there occurred in my practice in Baltimore a curious catarrhal condition which I regarded at the time as epidemic in nature. It differed essentially from ordinary colds in that it was apparently not the result of exposure and it affected almost invariably more than one member in a family and sometimes entire families. Last year no such case came under my observation.

In March of this year my attention was again directed to the same condition. My interest was aroused, after being summoned within one week to three families, in which either the entire family or several members of a family were similarly affected. Since then many other cases have come under my care which have enabled me to make a careful study of the affection from a clinical standpoint, and have furnished Dr. Stokes, who kindly offered to make a bacteriologic investigation, an opportunity to study the epidemic from an etiologic standpoint. In this work Dr. Stokes was assisted by A. E. Winlack and D. G. Preston, students at the College of Physicians and Surgeons.

As the following notes will show, these cases may be looked on clinically as measles without a rash, as conjunctivitis with general catarrhal symptoms, as whooping-cough without a whoop or as grippe without mental or physical depression. Since this group of cases presents a definite clinical picture—a symptom-complex not exactly corresponding to the familiar epidemic diseases—it appears to me not all improbable that the epidemic is an affection having a distinct entity.

This report is based on the clinical study of fifty-six cases, of which thirty-three were examined bacteriologically. I shall give the histories in full of a few of the most typical family groups of cases showing house infection, one case of the severest type of the disease, and follow these by a summary of the entire series:

GROUP 1.—My first experience was with the G. family, consisting of six members, all of whom were affected; father aged 42, mother 34, Pearl 18, Urban 6, Alfred 5, and baby 10 months. March 13, 1907, I was called in to see the baby, who was thought to be suffering from whooping-cough. The child had had none of the acute infectious diseases. Alfred and Urban had had whooping-cough one year ago. Alfred was the first one in the family affected with this catarrhal condition. The others, except Urban, were affected three days later. Alfred did not remember having played with children similarly affected, before he was taken sick. Later, two children in the M. family, living in the same block, developed similar symptoms. Alfred had been playing with these children during his illness.

The mother gave the following description of Alfred's illness: He began to complain of chills followed by slight fever and night sweats; this was associated with paroxysmal cough, discharge from the nose, watering of the eyes, slight soreness in the throat, slight pain in the chest and abdomen, and absolute loss of appetite. There was marked constipation. Vomiting frequently occurred after paroxysms of coughing. The cough was of a severe croupy character, and, at first, lasted half an hour. These attacks occurred more frequently during the night. There were four or more severe attacks at night and two or three lighter ones during the day. Occasionally during the night, these paroxysms terminated in a distinct whoop. When the child was first seen, the symptoms had subsided, except the cough and the discharge from the nose, which was at this time mucopurulent. He had a slight bronchitis and vesicles of chickenpox.

Urban, who was similarly affected, was also taken with chills and fever, which were followed by sweats. He had a peculiar dry paroxysmal cough, having three or four severe attacks at night, which lasted until he vomited. He had marked lachrymation without congestion, nasal discharge, sore throat, thoracic and abdominal pains, but no rash. The fever lasted about one week, during which he had several night sweats; anorexia was marked and he was very constipated.

Pearl's case corresponded closely to Alfred's and Urban's, except in the following particulars: Her eyes, at first watery, became mucopurulent and the lids were pasted together in the morning. In addition to the discharge from the nose, there was much sneezing. The cough, which was spasmodic in character, produced gagging after each paroxysm. Her appetite was not impaired.

The mother had the same train of symptoms; namely, fever, sweat, cough, sneezing, rhinitis, mild conjunctivitis, pain in chest, slight abdominal cramps, anorexia, and vomiting after paroxysms of coughing. Her symptoms lasted three weeks.

The father had the same symptoms, but a more intense conjunctivitis. His eyes were painful, watery and itching at the beginning; the conjunctivæ soon became injected and the eyes felt dull and heavy; photophobia was quite marked. There was slight frontal headache. The discharge from the eyes, at first serous, became mucopurulent. The eye symptoms subsided in four or five days. The respiratory and gastro-intestinal symptoms were less pronounced than in other members of the family. He had a sore throat, a moderately dry cough, not paroxysmal in character, no nausea, vomiting or anorexia, and no thoracic or abdominal pains.

The baby began with intestinal symptoms: viz., nausea, vomiting and diarrhoea. The cough appeared two days later, accompanied by fever, sweats, conjunctivitis, rhinitis, pharyngitis and bronchitis. The cough, which was severe, appeared in paroxysms, simulating fully-developed whooping-cough from the beginning. She had a mucopurulent conjunctivitis in both eyes, slight swelling of the eyelids and intense photophobia, the child burying her face in her mother's lap to shut out the light. A rhinitis, which began with sneezing, followed by serous discharge, became mucopurulent in character. The throat was uniformly red; the tonsils were not enlarged. The mother felt alarmed because the child refused all nourishment for several days. It vomited considerable mucus and had diarrhoea, passing, in 24 hours four to seven stools which contained much mucus and were highly offensive. The temperature was 102° F.; the pulse was rapid. Coarse bronchial râles were heard all over the chest. The liver and spleen were not enlarged. A slight heat rash was observed. Cover-slip preparations and cultures from the nose and the throat of the mother and the baby showed pneumococci.

GROUP 2.—May 10.—S. family. Four members were affected: Aunt K, aged 35, mother aged 40, and two children, Celeste aged 5 and Janette aged 7, both of whom had had measles and chickenpox. Mrs. M. and sister, living in a flat on the second floor of the same dwelling, were also affected. The first one affected was Mrs. M., who became ill about April 20. A week later Aunt K. was affected; Janette three days later; Celeste three days after Janette, and the mother a few days later than Celeste.

Aunt K.'s illness began with chilliness and fever followed by sweats, associated with cough, sneezing, discharge from nose and lachrymation. Later, the nasal discharge became mucopurulent, but that from the eyes remained watery. The eyes became painful. She suffered with burning and itching and was not able to read without considerable difficulty. Epistaxis occurred three times during the attack. Her throat was sore and she complained of dryness and hoarseness. There was substernal pain. The cough, which was dry, occurred in paroxysms, and occasionally there were associated sensations of choking, as if a foreign particle were lodged in her trachea. This was sometimes accompanied by vomiting of intensely tenacious mucus. There was also loss of appetite, which lasted two days.

Janette was taken sick three days after Aunt K. Her illness began with a distinct chill, which was followed by considerable fever and sweats, and by sneezing, nasal discharge, cough and mucopurulent conjunctivitis. The right eye was first affected; the left shortly after. The discharge from the nose, which was watery at first, became so thick and tenacious that it clogged the nostrils and the child was unable to breathe through her nose, especially in the morning. In order to relieve this obstruction, the mother resorted to the use of cold cream inserted into the nostrils, after which she was able to remove plugs of inspissated secretions by means of a hairpin. This procedure was carried out for five successive mornings. The cough, croupy in character, was worse at night than during the day and occurred in paroxysms. The tenacious secretions caused a choking sensation and vomiting, when an effort on the part of the child was made to remove them. There was complete anorexia. The bowels were constipated. The child suffered from headache, ear-ache and abdominal pains and also had considerable mediastinal pain. She complained of dryness of the mouth, great thirst and hoarseness.

Physical Examination of Janette.—The patient was up and about, but appeared somewhat nervous. Her eyelids were swollen, the upper more than the lower, and were of the peculiar rose color described by Axenfeld. There was a mild blepharitis and the eyelids were matted with dry, yellow masses of pus. The child presented a picture of adenoid facies and was breathing through her mouth. A profuse herpetic eruption was observed on the lips. There was a slight excoriation about the nares. The tongue was dry and slightly coated and showed several patches of aphthous stomatitis, which also appeared on the buccal mucous membrane. The mucous membrane of the mouth and pharynx were uniformly red. The tonsils were slightly enlarged; the uvula was swollen and edematous. The cervical glands were prominent. Coarse, dry râles were heard over the chest. Pulse and temperature were normal.

Celeste began to complain three days after Janette. She had played with Janette and had spent much time with the family, similarly affected, living in the upper flat. The subjective symptoms corresponded throughout with Janette's.

Physical Examination of Celeste.—The child was sitting up, but not disposed to play. Pulse, accelerated; evening temperature, 101.5° F.; skin, dry. The child breathed through her mouth. The eye symptoms were not as marked as Janette's, but were worse a few days before. She also had herpes and her tonsils were considerably enlarged. The mucous membrane was of a deep red color. While her throat was being examined, she was seized with a paroxysm of coughing, during which she gagged and expectorated a large amount of thick, tenacious, fibrinopurulent matter, portions of which were rusty in character, not unlike the sputum of pneumonia. This expectoration adhered to the bottom of the vessel containing it when inverted. Microscopic examination showed numerous pneumococci. The cervical glands were enlarged and painful. Coarse bronchial râles were heard all over the chest, otherwise the chest was negative. A blood examination showed a leucocytosis of 15,200, and the following differential count: Small mononuclear cells 20, large mononuclear 10.5, polymorphonuclear 69.5. Cultures and cover-slip preparations from the mucopurulent expectoration after vomiting, showed pure pneumococci.

The mother had a very mild attack; the most distressing symptom was the cough.

The disease ran a course of about two weeks in the case of the aunt and the two children. In the case of the mother it lasted only a few days.

One of the most interesting cases of this collection was treated in the Baltimore Eye, Ear, and Throat Charity Hospital. It was through the courtesy of Dr. Harry Friedenwald that I was invited to examine the patient and permitted to embody the history in my report. I am indebted to Dr. J. W. Downey, resident physician, for the history of the case, from which I have made the following abstract:

CASE 1.—The patient, a boy, aged 18 months, was admitted to the hospital April 25. The mother thought the child had measles a month previously, although she says the measles never "came out." The early symptoms of

the illness were hoarseness, cough, fever and lassitude. Several brothers and sisters were affected in the same way; none of them had a rash. The eye condition had existed one week previous to the admission to the hospital, and the eyes had been slightly affected during the whole course of the so-called "measles."

Examination.—This showed a fairly well-developed child, although rather poorly nourished. The lids of both eyes were swollen, so that the eyes were closed. The lids were soft to the touch. There was a slight mucopurulent discharge from both eyes and a slight eczematous eruption around the eyelids. The palpebral conjunctivæ of both eyes were much swollen, and covered with a slight, loosely adherent membrane. The ocular conjunctivæ were not covered with a membrane and were not edematous, but were very much congested. Examination of conjunctivæ caused bleeding. There was a cloudiness of the cornea of the right eye and a hazy appearance of the cornea of the left eye, but there were no ulcers. Impetigo pustules were observed on the face and body. There was a pale, stringy, nasal secretion. The voice was weak and hoarse, and his cries were crowing in character. The mucous membrane of the mouth and throat was slightly reddened, and there was a slight, dirty looking membrane, which appeared in patches, in the pharynx. The larynx also showed a few shreds of membrane. Cough was a distressing symptom. Moist bronchial râles were heard. The chest was normally developed and the heart was normal. Appetite was poor. The child passed from four to five diarrhœic stools daily; these were at times tinged with blood. The spleen was distinctly enlarged.

One thousand units of diphtheria antitoxin were at once administered, although cover smears and cultures on blood serum and agar later proved negative for diphtheria. The bacteriologic examination of the eyes showed almost pure pneumococci. A few staphylococci were also found, and staphylococci were obtained in cultures from pustules from the face and leg.

May 2, an ulcer developed on the right cornea. The left cornea was still cloudy, but no ulceration appeared. No improvement in general condition.

May 7, ulcer appeared on the left cornea.

May 17, the report showed that the child had had an almost continuous fever for three weeks previous, ranging from 99° to 100.3°. The eyelids were still swollen and the child was unable to open them. The intestinal symptoms had improved and the membrane from the eyes and throat had disappeared.

May 25, Dr. Friedenwald reported the recovery of this patient with maculæ of both corneæ.

CASE 2.—A parallel case is that of Mr. S., aged 23, who had a severe purulent conjunctivitis with small ulcerations on each cornea and a yellow, loosely attached membrane on the left inferior turbinate and on the left side of the naso-pharynx. The general appearance of the membrane was very suggestive of diphtheria and 3000 units of antitoxin were at once administered. Cultural and inoculation methods of examination, however, demonstrated a pure pneumococcic membrane.

I shall not give a detailed statement of other cases which resemble greatly those above reported. In the following I shall give a brief sum-

mary, based on the observations made on my own cases and those of several colleagues.

ETIOLOGY.

That this disease is of an infectious nature is evident from the report of the two family groups in this paper. In all except ten cases there was a history of house infection. Forty-six cases occurred in thirteen families. In a family consisting of eight members, only two girls were affected. They slept in the same bed. Another family, in which six were affected, the disease was distinctly traced to a servant who had the symptoms for three days before the general outbreak. An interesting example of the epidemic character is an outbreak on board a bay steamer, in which 20 per cent of the crew suffered the same symptoms, including the captain, chief engineer, second mate, and watchman. A smear from the engineer's throat showed epithelial cells containing as many as sixty pairs of encapsulated diplococci. The epidemic character of pneumococcus conjunctivitis has been pointed out by Hauenschild⁵ and its invasion of families by Bänzinger and Silberschmidt and by Veasey.⁶ Most of the cases of pneumococcus conjunctivitis which have been reported have not occurred in epidemics.

From a single observation, it appears that animals are not immune. In a family in which three members were affected, one of the patients was fondling a pet cat. Three days later the animal began to sneeze, which was followed shortly by a severe cough and a purulent conjunctivitis. Unfortunately, the cultures taken from the eye were lost and no bacteriologic examination was made. Collica⁷ was able to produce pneumococcus conjunctivitis experimentally in young dogs, but not in rabbits.

AGE.

The disease is met with more frequently in children. In twenty-nine of the fifty-six cases, it occurred under 7 years of age, ten of these were under 1 year, the youngest patients were twins, 8 weeks old.⁸ It occurred four times in the second decade, eight in the third, nine in the fourth, and five in the fifth; the oldest patient was the engineer above referred to, 56 years of age.

PREVALENCE.

All of my cases occurred in the spring. Epidemics of pneumococcus conjunctivitis have likewise been observed in the spring or in the fall.⁹

Many new cases have been brought to my notice since I concluded the study of this series. A number of physicians have informed me of meeting similar cases in their practice in Baltimore. Physicians in other cities have also seen numerous cases which correspond to this disease. No reference has been made in any of the medical journals, although the lay press recently reported epidemics of "colds" in London, Philadelphia, and Baltimore. These epidemics may possibly be of the same nature.

SYMPTOMATOLOGY.

The period of incubation ranges from two to seven days.¹⁰ The invasion is usually marked by chilliness, slight febrile disturbance, and occasionally night sweats. There is rarely a distinct chill. The temperature, usually from 99.5° F. to 102° F., continues from three or four days to one week. The highest temperature recorded is 103.5° F.; the pulse is not much accelerated. Sneezing, lachrymation and a mucous discharge from the nose are early symptoms. These are followed by a burning sensation in the nose, itching of the eyelids, and a slight soreness in the throat.

A spasmodic cough, croupy in character, usually worse at night than during the day and often associated with nausea, and even vomiting, is a fairly constant phenomenon. Occasionally the paroxysm terminates in a distinct whoop. In some instances the cough is less spasmodic and more hacking, like that of early tuberculosis. It is nearly always a dry cough, and, if expectoration is present, it occurs as an extremely tenacious, yellow mucopurulent excretion, which adheres to the bottom of a vessel when inverted, and rarely is it blood streaked. There is frequently an associated bronchitis, but the symptoms manifest a more profound inflammation of the upper air passages as indicated by a uniform redness of the mucous membrane of the nose, naso-pharynx, soft palate, larynx and vocal cords, and by hoarseness and a laryngeal or tracheal cough.¹¹

The eyes are also frequently affected; the usual symptoms are lachrymation and photophobia; the conjunctivæ often become injected, and in twenty-one of my cases (37.5 per cent) a purulent conjunctivitis developed. Two of these cases were complicated with corneal ulcers.

Profuse herpetic eruptions frequently occur. The tongue is generally dry and somewhat coated; loss of appetite and often complete anorexia

are distressing symptoms, especially in nursing children; nausea and vomiting of stringy, tenacious mucus, after paroxysms of coughing, is a quite constant feature. Constipation is the rule, although diarrhoea may ensue, with blood and mucus in the stools. Intense thirst has been noted in many of the afebrile cases, as well as in those accompanied with slight fever. Polyuria was frequently present. Vesical irritability was observed in three of the cases. In one the irritation was doubtless due to hyperacidity of the urine (70 cc. of deci-normal solution of sodium hydroxid were required to neutralize 100 cc. of urine in the presence of an excess of potassium oxalate). The urine is generally pale, highly acid, low in specific gravity and free from sugar, albumin, and casts.

A striking feature in the study of these cases is the absence of any marked nervous or mental symptoms. There is little or no mental or physical depression. Few of the patients were found in bed on my first visit, and practically all the children affected with the disease emphatically refused to stay in bed, even with a moderate fever of 101° F. or 102° F. Most of them did not feel ill or distressed except when seized with a paroxysm of coughing, during which they suffered from a severe choking sensation. In three instances I was hastily summoned, as the parents thought the children were dying from strangulation. During these attacks, which lasted only a few minutes, the patients became cyanosed and exhausted. Immediately after the attack they felt as well as usual. One patient, a girl of 20, had five such attacks in twenty-four hours. After a thorough cleansing of the larynx by means of an alkaline spray they promptly ceased.

Mild frontal headaches, substernal and epigastric pains are frequently complained of. Dr. H. C. Knapp furnished me with notes on an interesting case of pneumococcic bronchitis in which there was a pseudomembrane in the throat, and severe joint pains especially in both knees and ankles. With the exception of chickenpox vesicles in one case, sudamina vesicles in another, and impetigo in a third, no eruption was observed. Many cases developed a mild adenitis, especially of the postcervical glands. The spleen was only enlarged in those cases associated with severe intestinal symptoms. A decided leucocytosis was observed in all cases in which the blood was examined, ranging from 12,500 to 21,000.

SPECIAL SYMPTOMS AND COMPLICATIONS.

A significant feature of this disease is the formation of a pseudomembrane. This occurred in 12.5 per cent of all the cases. The membrane is of a light yellow color, usually situated in the nose, pharynx, or nasopharynx, and occasionally the conjunctiva. It is easily removed, but usually leaves a bleeding surface of the mucous membrane. Cover-slip preparations show an enormous amount of encapsulated pneumococci, and direct inoculation into animals produces pneumococcic septicemia. Severe bronchitis was present in ten of the cases. Some of them which have been carefully studied by Dr. Stokes prove almost beyond a doubt to be due to a pneumococcus infection. Vomiting of clear or bile-stained mucus after coughing occurred in 37.5 per cent of the cases. This appeared to affect small children more constantly than adults. Vomiting was often accompanied with intense retching. Diarrhoea complicated four of the cases in this series, all of which occurred in children under 4 years of age. They averaged from three to seven movements daily. The stools were thin, highly offensive, and contained a large amount of mucus which was occasionally streaked with blood. Fibrinous pleurisy complicated two cases and frontal sinusitis and purulent otitis media each complicated a single case.

It is strange to say that pneumonia did not develop in any of these cases, although Dr. C. F. Blake informs me that he has recently seen two cases follow an acute catarrhal condition, which answered the description of this disease.¹²

COURSE AND RELAPSE.

The average duration of the acute stage is from one week to ten days. The cough frequently persists much longer, and in some instances it continued for five or six weeks. Six of the patients had definite relapses; five occurred in young children and one in an adult. The interval between the subsidence of the primary attack and the onset of the relapse ranged from one to two weeks.

DIFFERENTIAL DIAGNOSIS.

If this is an independent affection, then it is necessary to differentiate it from: 1, measles; 2, whooping-cough; 3, influenza; 4, an epidemic catarrh due to the micrococcus catarrhalis, and, 5, epidemic conjunctivitis.

Measles.—The mere fact that there is a uniform absence of Koplik spots and rash should suffice. If, however, in addition, we consider the fact that having had measles does not lessen the susceptibility of the individual to an attack of this disease, we can safely exclude the possibility of measles.

Whooping-cough.—While it is true that in a small percentage of cases there is a distinct whoop, yet this appears as early as the second day of the illness and usually disappears within a period of one week. Moreover, the most typical cases that I saw, developed in children who have had whooping-cough.

Influenza.—With the exception of the absence of a mental and physical depression and severe nerve pains, the condition presents a close resemblance to influenza. Other differentiating features to be considered in the present epidemic are the tendency to the development of pseudomembrane and conjunctivitis; the peculiarly characteristic cough; the more or less persistent hoarseness, and, above all, the absence of the Pfeiffer bacillus.

Epidemic Catarrh.—This is generally a mild catarrhal affection and is not characterized by any gastro-intestinal symptoms. The characteristic organism, *Micrococcus catarrhalis*, was not found in any of the patients examined.

Epidemic Conjunctivitis.—As far as the eye symptoms are concerned, there are no distinguishing features to separate it from the epidemic pneumococcic conjunctivitis which was prevalent in a number of large communities in continental Europe in 1896, as described in the report of Kölle and Wassermann. These authors, unfortunately, merely called attention to the fact that there is associated an acute catarrhal condition, and look on the eye symptoms as the essential lesion. In this epidemic, the eye symptoms are subsidiary, the primary seat being almost invariably in the upper air passages, and, as already stated, only 37.5 per cent developed pneumococcic conjunctivitis.

TREATMENT.

The cough is very intractable and little influenced by ordinary cough mixtures. Antipyrin and the bromids diminish the intensity and frequency of the paroxysms. Much relief is obtained by a thorough cleans-

ing of the mucous membrane of the nose and throat by the use of an alkaline spray. The mild forms of conjunctivitis yield readily to the local application of boracic acid solution. The severe mucopurulent and membranous forms were successfully treated with 10 per cent argyrol solution. Quinin administered in large doses (twenty-five to thirty-five grains daily) has proved an efficient remedy. It has the effect of promptly reducing the temperature and lessening the cough and coryza.

From the clinical and bacteriologic study of these cases, we believe that this affection is an acute pneumococcic disease of a decidedly epidemic character.

BACTERIOLOGIC STUDY.

Before describing the findings in the bacteriologic study of this acute, inflammatory, communicable infection of the conjunctiva and upper air passages, it is proper to mention the various bacteria which are found in diseased conditions of these mucous membranes.

The conjunctival epidemic inflammations are usually produced either by the Koch-Weeks bacillus or the Morax-Axenfeld organism. The former bacillus is very small, decolorizes by Gram's method, is found in and outside of the pus cells, and will only grow on blood agar or other similar media. The latter organism is a much larger, thicker bacillus which often occurs in pairs and also decolorizes by Gram's stain. It may be cultivated on blood serum. Among the other bacteria may be mentioned *B. diphtheriæ*, *Micrococcus gonorrhæa*, *Staphylococcus aureus*, *Streptococcus pyogenes*, *Meningococcus intracellularis*, *Bacillus coli*, *Bacillus pyocyaneus*, and *Diplococcus pneumoniae*. Any of these organisms also may produce inflammation of the mucous membranes of the throat and nose.

In most of the cases which we examined bacteriologically we found the *Diplococcus pneumoniae* at times in combination with the pyogenic micrococci, and the pneumococcus has previously been reported by several investigators as the cause of epidemic conjunctivitis. These outbreaks are described in Kölle and Wassermann's Bacteriology, 1903.

The first cases of pneumococcic conjunctivitis were reported by Parinaud¹³ and Morax¹⁴ in 1894 as occurring in newborn infants and young children, and these cases were accompanied by lachrymation, coryza, and

purulent and fibrinous inflammation of the conjunctival mucous membranes.

Gasparrini¹⁵ and Axenfeld¹⁶ in 1896 reported many cases of pneumococcal conjunctivitis in children and adults, and they considered the infection communicable.

The geographic distribution of this disease is widespread, and epidemics have been described as occurring in several cities in Germany, Austria, Italy, Denmark, Switzerland, Russia, Egypt, and the United States. In these cases the inflammation was limited to the conjunctiva, and we have been able to find only one case reported by Denig¹⁷ in which this condition was accompanied by an angina, or fibrinous inflammation of the throat.

It is difficult to produce an inflammation of the conjunctiva in rabbits and other animals by means of the pneumococcus, although this has been accomplished after scarifying the conjunctiva. The history of the outbreaks among human beings, however, makes it highly probable that the condition is communicable, and this was proven by Gifford¹⁸ and von Pichler,¹⁹ who produced the disease in healthy persons by inoculating their eyes with pure cultures of the pneumococcus obtained from cases of epidemic conjunctivitis. Hauenschild²⁰ produced the disease by inoculating the pus from the eye into healthy eyes, and proved an incubation period of about two days.

From what has been said it can be seen that the clinical picture of this condition has almost entirely related to the conjunctiva. Dr. Beck, however, has demonstrated that the mucous membranes of the throat and nose are also frequently affected both by purulent and fibrinous inflammations, and in our bacteriologic studies we have made routine cultures from the nose, throat, and eye of all the cases examined. In addition, in most of the cases, we have examined cover-slips from the eye, nose, and throat, and the cultures have frequently been inoculated into white mice or rabbits to prove the virulence of the pneumococcus.

So far we have studied 33 cases, and by microscopic examination have found pus cells and pneumococci in 7 specimens from the nose, 9 from the throat, and 10 from the eye. Capsules were stained by Welch's method in 1 preparation from the nose, 3 from the throat, and 2 from the eye. We failed to find pus cells and pneumococci in 2 specimens from the

nose, 1 from the throat, and 3 from the eye. No microscopic examinations were made of the other cases.

The pneumococcus was found in cultures in 8 cases from the nose, in 2 of which fibrinous membranes were present, and in 23 cases from the throat, in 4 of which membranes were present. In 7 out of 17 cases the cultures from the eye contained pneumococci, and in the rest of the 33 cases the eyes were not examined. The original cultures from most of our cases were inoculated into white mice, and the pneumococci often proved virulent, killing the animals with general septicemia in from 1 to 11 days. The cultures from the eye produced pneumococcic septicemia 3 times and those from the throat and nose each 5 times.

In the second series of 16 cases we inoculated 8 rabbits intravenously with pure cultures from the throats of the patients, and 5 died of general pneumococcic septicemia. In 29 out of 33 cases the pneumococcus was obtained either from the nose, throat, or eye by cover-slips, cultures, or animal experiments.

In order to exclude the Koch-Weeks and influenza bacilli, cultures were made from the throat and eye in 5 cases on blood agar with negative results. We also failed to find any of those very fine, Gram-decolorizing bacilli in the microscopic examinations of cultures from the eyes, nose, and throat, and think that this organism may be excluded as a causative agent. In many of the cases we obtained the pneumococcus in pure cultures, but some of the throat and nose cultures contained the *Staphylococcus aureus* and *albus* and the xerosis bacillus. Several cultures from the eye showed the presence of these pyogenic micrococci. We think that these organisms are secondary invaders and that the inflammatory condition can be produced by the pneumococcus alone.

In several of the cultures from the pus from the eyes and membranes in the nose and throat and in cover-slips from these materials only pneumococci were found. Frequently the pneumococci were within the pus cells showing phagocytosis. We consider this, therefore, the primary infectious agent.

These cultures gave the usual cultural and staining characteristics of the *Diplococcus pneumoniae*, although we made no attempt to distinguish between the two forms of the organism, in respect to its effect on culture materials containing inulin. The diagnosis was based on the presence of

capsules, the coagulation and acidulation of milk, the clouding of bouillon, and its failure to grow well in gelatin.

In ascribing to the pneumococcus the causative rôle in this disease, we have not disregarded its presence in the normal mouth and throat. The "Report of the Medical Commission for the Investigation of Acute Respiratory Diseases of the Health Department of the City of New York" contains several investigations which show that the pneumococcus is an almost constant inhabitant of the throat and mouth. Park and Williams found either typical or atypical pneumococci in 51 out of 80 normal mouth secretions examined, and Longcope and Fox found typical pneumococci in 19 out of 40 normal throats which they examined. Duval and Lewis isolated this organism in all of 24 healthy persons examined, and Berger found it in 110 out of 283 normal throats examined. The pneumococcus, therefore, can be considered an almost constant inhabitant of the mouth and throat.

But when this organism is discovered in diseased conditions of the mucous membranes, usually in pure culture, frequently virulent, and so distributed in purulent and fibrinous inflammations as to explain these conditions, we have no hesitancy in considering it as the cause of the condition. The photomicrographs from typical cases also show the organism in large numbers, often within the pus cells, showing active phagocytosis, and this is a further point in favor of its being the cause of the disease.

CONCLUSIONS.

This disease exists as a distinct entity, characterized by purulent or fibrinous inflammation of the mucous membranes of the eye, nose, and throat.

The infection can be communicated from diseased to healthy persons.

The infection is caused by the pneumococcus, resembling in its cultural and pathogenic properties the cause of lobar pneumonia.

REMOTE EFFECTS OF THE DISEASE.

It is interesting to note that, since the completion of this article in June, 1907, three out of the seven patients, under one year of age, have died. Two (twins) died of acute tuberculosis; one within three months of the primary disease, the other within four months. An autopsy on the

first one of the twins showed general lymphatic and pulmonary tuberculosis. The third patient of this series died from catarrhal entero-colitis. Another case, a girl of eighteen, who had a severe attack of the disease, has also developed pulmonary tuberculosis, and has recently had two pulmonary hemorrhages. Dr. Friedenwald's case, reported at length in this article, has developed acute anterior poliomyelitis. It thus appears that the disease is not as benign as one is led to believe from the more or less mild train of symptoms which usually characterize the primary attack.

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A POEM BY DR. PRESTON.

Dr. Standish McCleary has very kindly furnished the JOURNAL with the following:

Sometime during the early "90's," while helping Dr. Preston to conduct one of his examinations, the historical novel came under discussion and I remarked that I had just read for the third time and with increasing enjoyment "The Three Musketeers." Dr. Preston said it was an old favorite of his and he intended going over it again. I left him seated at a table, and when I had made a round of the examination room, Dr. Preston called me over to him and handed me the following lines, jotted down on a piece of examination paper:

LES TROIS MOUSQUETAIRES.

When all the days are dull and stale
And life creaks on with rusty wheels
And over every sense there steals
The tedium of the twice-told tale,
I snatch an hour or two of bliss
With Athos, Porthos, Aramis.

When daily bread is hard to get
And toil relentless drives the plough
And deepens furrows on the brow;
So soon the tiresome sun hath set
I snatch an hour or two of bliss
With Athos, Porthos, Aramis.

When care and trouble come amain
As come they will, as come they must,
And grind our dry mouths in the dust
I've found a solace to the pain.
I snatch an hour or two of bliss
With Athos, Porthos, Aramis.

Immortal heroes of Romance
My dull ears rouse at clash of steel;
A thrill in every pulse I feel.
I'm with you on the plains of France!
Ah! I *must* snatch my hour of bliss
With Athos, Porthos, Aramis.

L'ENVOI.

Master, thy cunning hand hath shed
Such genial light o'er darkened days;
Each generation swells thy praise
And puts fresh laurels round thy head.

WILLIAM S. GARDNER, M. D., EDITOR,
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500 E. Twentieth St.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

DR. CRAWFORD'S INVESTIGATIONS.

Dr. Albert C. Crawford, '93, is now located in Washington as pharmacologist to the Bureau of Plant Industry of the Department of Agriculture. Among his recent publications are three pamphlets: "The supposed relationship of white snake-root to milk-sickness or trembles," "Laboratory work on the loco-weed investigations," and "Mountain laurel as a poisonous plant." The most important work in which Dr. Crawford has been interested are the loco-weed investigations. Loco, from the Spanish meaning crazy, has been applied for a great many years to a disease of stock and sheep in the semi-arid regions of the west. There has been a general belief among stockmen that the disease is caused by certain weeds known as loco-weeds. The name, loco-weeds, has been applied to a large number of plants, but two of them are considered especially poisonous. The government undertook the scientific investigation of these plants in 1905 and demonstrated the poisonous species. In 1906, the work was mainly devoted to the diagnosis of the disease. The external symptoms described by stockmen, were in general corroborated. The principal symptoms are the lowered head, rough coat, slow staggering gait, movements showing lack of muscular co-ordination and more or less paralytic symptoms, general disease of the nervous system, and in later stages of the disease extreme emaciation. The pathological changes were also studied. In 1907 the third stage of the work, the devising of

remedial measures, was undertaken, the two problems being, first, an attempt to eradicate the disease, and, second, to cure the disease in animals. It was found possible in fenced pastures to kill off the weed, but so far no way has been devised of ridding the ranges. The most valuable method of treatment consisted in preventing the animal from eating the weed, administering magnesium sulphate, and for cattle a course of treatment with strychnine; loco in horses can generally be cured by a course of Fowler's solution. It was also found that the inorganic constituents, especially barium, are responsible for this poisonous action. It is found that loco plants growing on certain soils are inactive pharmacologically and contain no barium. It has been estimated that the loss from this source in Colorado alone reached the sum of one million dollars in a year. This work is undertaken under the direction of the Office of Poisonous Plant Investigations, of which Dr. Rodney H. True is physiologist in charge. The field work is done by Dr. C. D. Marsh and the laboratory by Dr. Crawford. This opens up an interesting line of research work in the chronic poisonous conditions of various plants, particularly that known as Lathyrism.

NOTICE TO CLASS '79.

The flashlight picture, which turned out very well of the class reunion of the class of '79, can be obtained from Bachrach Brothers, Baltimore, for \$1.50.

Obituary.

DR. HOWARD L. HAWKINS, '96, died at his home in Pine, Colo., Nov. 30, 1907.

DR. LEWIS M. TIPPETT, '92, died suddenly of heart trouble at his home in St. Mary's County, May 1, 1908.

DR. FELIX H. COYLE, '86, of New York City, died in Harlem Hospital, July 10, it is said, from the effects of prolonged exposure to the sun for the relief of rheumatism.

DR. JOHN D. MULHANE, '83, for many years local surgeon of the Pennsylvania System, at Steubenville, Ohio, died in the State Hospital, Athens, Ohio, July 15, from pulmonary tuberculosis, aged 50.

DR. JOHN C. F. BUSH, '84, of Wahoo, Neb., a member of the American Medical Association and Medical Society of the Missouri Valley, district surgeon of the Union Pacific Railway, and local surgeon for the Chicago & Northwestern System, died June 4, in Warren, Pa., where he had gone en route to Europe, aged 51.

Personal Notes.

DR. and MRS. CHARLES H. HALLIDAY, of Fort Sam Houston, Texas, have an addition to their family in the shape of a girl, born September 9, 1908.

MRS. LEWIS M. TIPPETT writes that there is an excellent opening for a physician at St. Inigoes, St. Mary's County. Where there were formerly three physicians there is now only one.

DR. ROSS ANDERSON has located in Salt Lake City, where he is professor of pathology and pathological anatomy at the University of Utah, and pathologist to Groves Latter Day Saints Hospital.

DR. J. G. PALMER, '84, of Opelika, Alabama, delivered the oration at the fourth semi-annual meeting of the Chattahoochee Valley Medical and Surgical Association at Auburn, Alabama, July 14. Dr. Palmer has a sanitarium at Opelika and in the correspondence of this issue there is a letter from him.

DR. IRVIN HARDY, '03, and DR. A. P. BUTT, '95, have opened the Allegany Heights Hospital and Sanitarium at Davis, W. Va., and expect to pay especial attention to the diseases of children. Davis is on the Western Maryland Railroad, and can be reached the same day from Pittsburgh, Washington, and Baltimore.

DR. SAMUEL W. FAIRCHILD, treasurer Fairchild Brothers & Foster, New York, was given a degree of Master of Pharmacy by the Philadelphia College of Pharmacy. Four others from different sections of the United States received the same honor at the same time. This is the first time in several years that this degree has been conferred in Philadelphia.

Marriages.

DR. THOMAS ROBERT FRANCIS was married August 10, at Buckhannon, W. Va., to MISS MARTHA JEANNETTE DAILEY. Dr. and Mrs. Francis will make their home at Connellsville, Pa.

DR. J. G. ONNEN was married in September at the parsonage of the Harlem Avenue Methodist Episcopal Church to MISS MIAMI BERTHA WAGNER, daughter of Mr. and Mrs. M. J. Wagner, 2620 E. Baltimore St., Baltimore, and niece of the late Martin Wagner. After the ceremony, Dr. and Mrs. Onnen left for a trip, which included the Hudson and Catskill mountains and two weeks in Atlantic City. They are now living at the southeast corner of Fairmount Ave. and Potomac St.

Correspondence.

THE AUTHORSHIP OF THE CLASS SONG OF '79.

ROANOKE, VA., August 25, 1908.

DR. C. E. BRACK.

My Dear Doctor.—I herewith enclose a letter from Dr. F. W. Larison, of Lambertville, N. J., which explains itself. I have written Dr. Larison that I had sent you his letter and requested you to make the necessary correction in the next issue of the ALUMNI JOURNAL and give him and the class of '85 credit for the class song, instead of the class of '79, which I am sure you will do. I want to thank you for the class of '79, and for myself personally, for the nice write-up you gave our reunion in the last issue of the ALUMNI JOURNAL. I prize my class reunion picture very highly—have had it framed and keep it hanging in my private office. With kindest regards and best wishes, I am,

Yours very truly,

GEO. H. P. COLE.

LAMBERTVILLE, N. J., August 6, 1908.

GEO. H. P. COLE, M. D.

Dear Doctor.—How can your class of '79 claim the class song which is in the July JOURNAL? I wrote the song in '83 for the University of Vermont and in '85 I transposed it for the College of Physicians and Surgeons and added the fifth verse. I have the one of '83, and if you would like it I will send it to you, but this belongs to '85. I am of '85, and we want what belongs to us.

Yours fraternally,

F. W. LARISON.

CLASS REUNION OF '84.

KINGSTON, N. Y.

Dear Dr. Hall.—I will be present at the reunion unless something in future prevents.

J. S. ROBINSON.

RICHMOND, VA., July 10, 1908.

Dear Doctor Hall.—I hope to be present at the '84 class reunion in June of next year. Hope you have been getting along all right. I remember you very well and wonder if you have forgotten me.

Yours,

W. H. COFFMAN.

OPELIKA, ALA., June 8, 1908.

DR. CHARLES E. BRACK, Baltimore, Md.

Dear Doctor.—I have thought for some time that I would write you as a member of the class of '84 and tell you how much I have enjoyed the JOURNAL. I have thought each year that I would attend the Alumni Association meeting, but something has always interfered, as is usually the case with the general practitioner. I am very anxious to see my preceptor, Dr. Chambers, to whom I owe, in a great measure, whatever of

success I have accomplished. I am anxious to see the professors yet living who were active in trying to make doctors of the material available of the class of '84. I guess, however, it would be somewhat sad to visit the dear old school and miss those who have gone to the great beyond. Opie, Coskery, Lynch, Arnold, Latimer, and Friedenwald have all crossed to the great beyond, and each one has left many good men who are perpetuating their noble lives and are to-day demonstrating the well-known facts, as gifts were theirs are given us as guardians of posterity. I am very much in favor of the meeting of the class of '84 and will do all I can to make the occasion a success. Know it will be great to meet with the boys and talk over the days of long ago. I have been practicing here, practically, since my graduation and have met with much success. Have held some positions of honor and trust and feel that I have the confidence and esteem of the people whom I serve and among whom I have spent the greater part of my professional life. I send check, which I hope will suffice to cover any indebtedness due; if not, say so, and I will send more. We have several P. and S. graduates, all of whom are doing well, and are reflecting credit upon their alma mater. However, this is proverbial, as wherever you find a graduate of our school you will find a man whose brain is well stored with practical facts, and these men are doing the best work and bringing or gaining many practical facts to enrich professional research. If I can aid you in any way in making the meeting of the class of '84 a success, please command me. I am sending you under separate cover two pamphlets, productions of mine, which you can read if you like, and then consign them to the waste basket.

Yours sincerely,

J. G. PALMER.

KINGSTON, N. Y., August 1, 1908.

Dear Doctor.—In the JOURNAL you were inquiring for a commencement program of '84, which I enclose, and seeing they are scarce, please return.

You will note that P. Robinson should be Jabez P.; F. E. should be T. E. He was a friend of mine from the Eastern Shore of Maryland.

J. S. ROBINSON, M. D.

WHEELING, W. VA., June 22, 1908.

DR. CHAS. E. BRACK, Baltimore, Md.

My Dear Doctor.—Enclosed find check \$3 for the JOURNAL.

Kindly inform Dr. A. C. Gillis that I will be present at the reunion of the class of '94.

Give my regards to all the faculty and oblige,

Yours very truly,

A. B. NICHOLS.

FINDLAY, OHIO, June 25, 1908.

CHAS. E. BRACK, M. D., Baltimore, Md.

Dear Doctor.—I enclose you \$2 to credit me for the JOURNAL. I have just returned from the Modern Woodmen Convention and expect to be chosen head physician for the society for another term of three years. Success to the JOURNAL and all P. & S. boys.

Fraternally,

DON C. HUGHES.

ARCADIA, PA., June 12, 1908.

DR. C. E. BRACK.

Dear Doctor.—Find enclosed check for five dollars (\$5). Please place to my credit on ALUMNI JOURNAL.

I have been located here two years and usually have a good deal of work.

Best regards to you and all the rest of the professors.

Yours,

R. E. SCHALL.

RUSH RUN, W. VA., June 25, 1908.

Dear Doctor.—You will please find enclosed my check for \$2 in payment of subscription to JOURNAL for 1907 and 1908. I enjoy the JOURNAL very much and was glad to get your statement a few days since reminding me that I had failed to remit.

Very truly yours,

WM. VERNER DUNLAP.

BALTIMORE, MD., May 15, 1908.

DR. CHARLES E. BRACK.

My Dear Friend.—In reading the JOURNAL for April, 1908, I noticed a communication from Dr. J. M. Patton, of Vandergrift, Pa., in which he says he would be very glad to hear of any members of the class of '84, '85, or '86, many of whom he knew personally.

I wonder if the Doctor remembers Robert E. L. Hall, from "Missouri," class of '84?

"Of the names Dr. Patton mentions, I distinctly recall those of Drs. A. E. Heilman, Sooy, Coughlin, and of course Drs. Bressler and Gardner, both of whom are located in Baltimore.

Dr. Heilman and I, both of the class of '84, were warm friends and I am deeply pained to learn of his untimely death.

Although a graduate of the dear old C. P. & S., I have never entered actively in the practice of medicine.

I conducted the retail drug business in this city for a number of years, and having conceived a taste for the law, I graduated in that profession in May, 1894, since which time I have been actively engaged in the practice of the law.

My interest in and fondness for my old alma mater, however, still continues, and I would be delighted to hear from any of the members of either the class of '83, '84, or '85, who may feel inclined to renew old acquaintances.

Very truly and sincerely yours,

R. E. L. HALL.

ORIENTAL, N. C., June 23, 1908.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Sir.—Enclosed you will find check for \$1 for the JOURNAL. I enjoy reading the JOURNAL, and am always glad to get news from old P. & S. boys. Please change my address to Oriental, N. C. Have recently come here to take charge of contract practice for one of John L. Roper's lumber plants, etc.

Very truly and fraternally,

C. A. FLOWERS.

SOUTH CHARLESTON, OHIO, June 25, 1908.

CHAS. EMIL BRACK, M. D., Baltimore, Md.

Dear Doctor.—Enclosed please find a draft for \$2, as per statement of my indebtedness to the ALUMNI JOURNAL. I want the JOURNAL to continue and whenever I am in arrears promptly let me know and I will remit.

The JOURNAL contains some very excellent articles, besides it keeps the P. & S. family slightly in touch with each other.

While it is a fact that a very few men in all business and professions achieve greatness, nevertheless, we who are mediocre in our vocation in this life, love to hear of our college mates and associates getting on well in the world, which the JOURNAL tells us about.

I was disappointed in not getting to Chicago to the A. M. A. meeting, as I know I would have met a good many old friends, but professional business kept me at home.

Hoping to be with you at some future alumni meeting, and with kindest regards and best wishes to my old friends and success to the JOURNAL, I am,

Most respectfully,

JOHN J. MOORE.

CHERETON, VA., July 1, 1908.

Dear Doctor.—You will find enclosed check for one dollar for subscription for JOURNAL for one year from date. I have been very much engaged since my return from Baltimore. Hope to have the pleasure of meeting class again in five years. We certainly had a pleasant reunion. Sorry I could not have seen more of you all, but had to hurry home. Kind regards to all.

Fraternally yours,

JULIUS HALL, '79.

FORT STANTON, N. MEX., May 14, 1908.

DR. CHARLES EMIL BRACK, Baltimore, Md.

Dear Doctor Brack.—I enclose herewith one dollar for subscription to ALUMNI JOURNAL. If I owe more please let me know and I will forward

it. I find it very easy to forget such things in a busy life, but I am reminded now of my neglect by the receipt of your April number, and wish to thank you for the compliment paid me recently in copying my article on the climate of New Mexico.

With kind regards, I am,

Very truly yours,
P. M. CARRINGTON.

WASHINGTON, N. J., June 26, 1908.

My Dear Doctor.—Enclosed you will find P. O. to the amount of two dollars to cover my indebtedness to the Association for 1907 and 1908.

I was very sorry to read a few days ago of the death of our old friend, Prof. Preston. One by one they are dropping out from the faculty, and one by one I find them leaving our classes.

With best wishes for our old College, I remain,

Sincerely yours,
C. B. SMITH.

BRANDON, TEXAS, June 29, 1908.

Dear Doctor.—Please find enclosed my check for \$1.00 for the JOURNAL subscription. I hope to be able to attend the reunion of the class of '84 and look forward to that event with great pleasure.

Fraternally,
J. W. SPALDING.

MOUNT ALTON, PA., July 17, 1908.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Your notice just received for subscription, for which please find enclosed my check for \$3.00, which apply to my arrears or extend my subscription. I am trying to make a living up on the top of the Alleghany Mountains in the Pennsylvania oil fields, and I am pretty well satisfied with my collections, even if I am in a desolate place.

With kindest regards to all, I am,

Fraternally yours,
S. R. FRAKER.

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Recognizing the therapeutic possibilities in the new Opsonic treatment, two years ago we sent one of our research bacteriologists to the laboratories of Sir A. E. Wright (in London) to study at first hand the subject of vaccine production. Since that time we have supplied large quantities of the various bacterial vaccines to clinical experts in this country with a view to determining their value as therapeutic agents, stipulating that the physicians advise us as to the results of their experience. In this way we have collected a mass of information concerning the utility of these products which demonstrates that, in properly selected cases and in competent hands, they yield good and at times brilliant results. (In improper cases, or in incompetent hands, the effects may be negative or even harmful.) Professor Wright believes that the question of Opsonic therapy has reached such a state as to warrant offering bacterial vaccines to the medical profession, and at his request our London house has undertaken to market in Great Britain and on the Continent of Europe the vaccines prepared in his laboratories; to the medical profession of America we will supply similar products from our own laboratories, as noted below:

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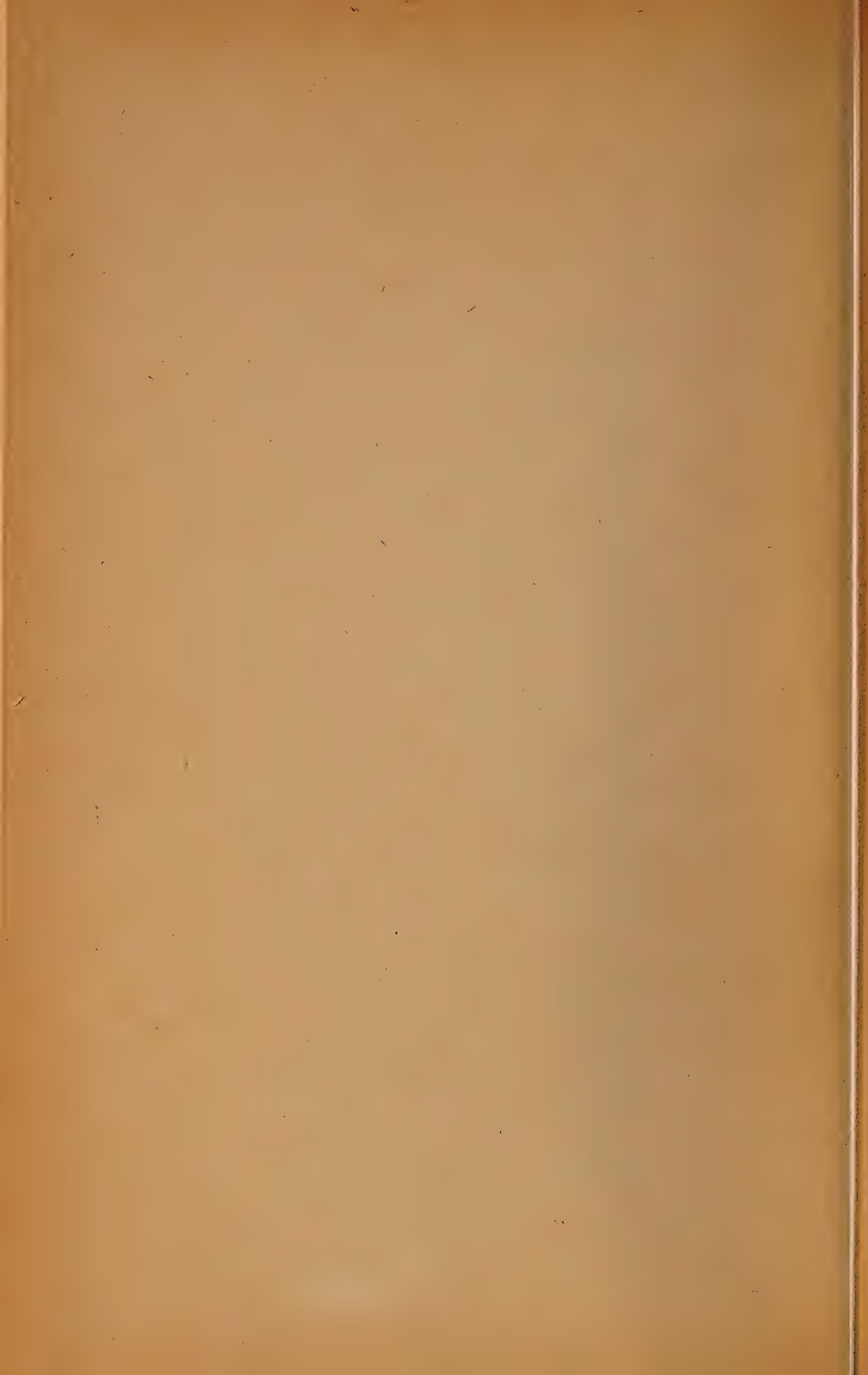
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JANUARY, 1909

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BALTIMORE.

GEORGE JUNKIN PRESTON, M. D.

BY DR. W. SIMON.

Death has dealt harshly with the faculty of the College of Physicians and Surgeons during the last few years. Memorial meetings, held in honor of our departed friends, have followed in rapid succession. In 1901, we gathered in this hall mourning the loss of George H. Rohé, that gifted man who in unique versatility wrote text-books on such widely different subjects as "Hygiene," "Skin Diseases," "Medical Electricity," and who was engaged in a work on "Mental Diseases" when his labors came to a sudden end.

Scarcely a year later Professor Aaron Friedenwald was taken from us. His life-work as physician, teacher, philanthropist, and representative citizen is well remembered by thousands, and the medical profession is more especially indebted to him for having been first in recognizing the necessity for the formation of an association of medical schools, and who also took the first steps in its accomplishment; this resulted in the organization of the Association of American Medical Colleges.

Two years ago Professor Thomas Latimer died, and in him the faculty lost a counsellor; the student, a friend; the profession, a co-worker of unsurpassed abilities.

Another year and Professor Isaac R. Trimble was stricken down upon that field on which the surgeon leads the battle with disease and death. His name is inscribed upon the roll of honor as one of the heroes, who sacrificed their lives to professional duty. And when the students, in

grateful remembrance of their beloved teacher, presented to the College the portrait of Professor Trimble, it was accepted on behalf of the faculty by Dr. George J. Preston, as president of our College.

The lips, which then spoke, are now sealed; the eyes, which then sparkled, are closed forever. And we have gathered in this hall for another memorial meeting. To me has been assigned the task to speak of our departed colleague as man and friend, leaving it to others to speak of him as physician, scientist, and teacher.

It has been my good fortune to know Dr. Preston well. For fully twenty years we worked and labored side by side for the welfare of our institution. I thus had the opportunity of becoming well acquainted with the character, the talents, the aims, and objects of this gifted man. You all know the answer given by Emerson to a mother who asked at what time the education of a child should commence. It was: "At least a hundred years before birth." Preston had the advantage of this pre-embryonic education, as both parents were distinguished by culture, intellectuality, and refined taste, and both could proudly point to a line of noble ancestors.

Dr. Preston's father was Major J. T. L. Preston, Professor of Languages and Belles Lettres at the Virginia Military Institute, and served as lieutenant-colonel in the Confederate army. His mother, well-known for her poetic gifts, was Margaret, daughter of the late George Junkin, D. D., of Philadelphia, and a sister-in-law of General Thomas (Stonewall) Jackson.

When to these parents, then living in Lexington, Virginia, a boy was born on July 2, 1858, he was named for his maternal grandfather, George Junkin; but he also inherited from him certain moral and intellectual gifts, along with his honored name.

Little George had not only the benefit of growing up in a delightful home atmosphere, but also the advantage of being reared in the country, the handsome and comfortable mansion of Colonel Preston being surrounded by many acres of lawn and garden. When the boy's legs had grown long enough to bestride an animal, he came into the possession of every Virginian's inheritance, a riding horse of his own; and when shortly afterwards a rifle was added to his possession he eagerly followed the hounds in the fox hunt, or went to the mountains in the fall with the

deer hunters to spend several weeks in camp, stalking deer, killing rattlesnakes, and living on venison. It was a lively and thrillingly interesting experience at such times for the boy.

With the physical development derived from such outdoor life, the mental training kept pace. Colonel Preston had devoted his life to educational pursuits and closely watched the boy's progress in his studies, especially in those relating to languages: Latin, Greek, and French.

After passing through the preparatory schools of Lexington, and partly through the Hampden-Sidney College, young Preston took his degree of A. B. at the Washington and Lee University in 1879.

By this time he had fully made up his mind that his life-work should be devoted to medicine, and that he would prefer to study at the University of Pennsylvania. But in order that the young man should enter upon his medical studies with the full understanding of what was before him, the father persuaded George to spend a year with Dr. John A. Graham, surgeon at the Virginia Military Institute, and in order that George might have the experience of as wide a range of methods as possible, a year was spent at the University of Virginia, before finally the medical education was completed at the University of Pennsylvania, where he received the degree of M. D. in 1883.

Receiving the appointment as resident physician in the Presbyterian Hospital, Philadelphia, Preston spent two years in that institution, and then moved to Baltimore, where he opened his office. Not being overrun by patients, he spent much of his time at a public dispensary, then located on Hanover St. It was in the first year of Preston's residence in Baltimore that an incident occurred that may be mentioned here.

Colonel Preston had never been quite satisfied with his own career as scholar, teacher, writer, dreamer, and he was most anxious that his son should be engaged in the more active and practical work of the world. So when the father spent a day with his son, shortly after he had settled in Baltimore, naturally enough one of the first questions asked by the colonel was: "How are you doing now?" To which the answer came: "Why, father, I am awfully discouraged; I have been here a month or two and I am as yet not doing anything, nothing at all." "Oh, well," answered the father, "you must not be impatient, work will come to you in good time."

In the course of the morning Dr. Preston took his father to the city dispensary, where he spent two very busy hours looking after a score of patients during that time. The father sat by, a quiet but deeply interested spectator, and when the last patient had left, he burst forth: "So you call this doing nothing?"

"But father, I don't get a dollar out of this work!" complained the young doctor.

"A dollar! Who is talking about dollars!" shouted the old Virginia gentleman, in fine scorn. "If I could feel to-night that I had helped twenty of my fellow-beings, as you have done, I would lay my head on my pillow, not caring whether I saw another dollar or not."

While attending to his little private practice and doing much work at the dispensary, the young physician became more and more interested in diseases of the nervous system and resolved to make a study of them. Realizing that the men doing the best work in this direction were in Europe, Preston went there, studying for some time under Professor Charcot, of Paris, then the greatest living specialist in nervous diseases. He also visited London and Leipzig, in order to become acquainted with the teachings of men, who were considered by the profession as authorities in the field of neurology.

After his return to Baltimore, Dr. Preston was offered and accepted the position as Professor of Physiology and Nervous Diseases in our College. This position, along with many others, he filled with extraordinary ability, up to the time of his all too early death, which occurred on June 17 of this year.

And now, after having given these data relating to Dr. Preston's career, let us look at the man as he stands before our eyes and lives in our memories.

Dr. Preston was a man, who, through his large, well-built frame, his broad chest, and intelligent head would not go unnoticed in any gathering of men; and when drawn into conversation there would come life into his face, the eyes would sparkle, and a smile would play around the lips.

And such conversational powers! They were inherited from father and forefather, who had been trained to speak from the pulpit, in the lecture-hall, or court-room.

Preston's high intellectual powers extended in many directions. I

have not to speak of his scientific attainments, but some of his mental gifts should not go unmentioned. He was so fortunate as to possess an unusually developed sense for the humorous side of life and this happy faculty was constantly brought out in conversation, which he readily interspersed with wit and humor. As a story-teller he was generally admired, and between lecture hours he was the one we looked to in the faculty-room for a little enlivenment by anecdote or story. This gift made him also a fine after-dinner speaker and on many occasions he acted as toast-master, to the delight of those present.

Some years ago he had been invited before hand to be one of the speakers at an alumni banquet. When his time came to speak he drew forth a paper and read a charming poem as his answer to the toast proposed. Sitting next to him, he explained to me how much easier it had been to express his thoughts in verse than to prepare a speech in prose.

This poetic vein, inherited from his mother, made itself felt on many occasions, and at times the impressions received would cause him to formulate them into poetry almost unconsciously. As an instance of this kind, I will select a sonnet which he wrote in Switzerland upon beholding the golden-reddish glow on the snow-clad mountains after a sunset.

ALPENGLOW.

Softly the darkness falls upon the plain,
And shuts the snow-capped mountains from the sight
Of eager eyes, that gaze with new delight
On nature's solemn grandeur, when again,
Like far-off echo of some sad refrain,
There steals a rosy-soft, unearthly light,
Along the glistening snow above the night,
That fills the valley with its dusky train.

Thus memories of dream-like long ago,
With tender, half-forgotten joys replete,
Gleam far above the darkness 'neath our feet,
For one brief, happy moment ere they go.
How sad they are, and strange, but passing sweet,
These fitting visions of life's Alpenglow!

It was this inborn poetic feeling which made him a lover of such quiet and unostentatious charms of nature as a fern-covered nook in the rocks, a cluster of old trees in the meadow, or a clear brook winding through a valley. The selection of his country home was, no doubt, made chiefly for the idyllic surroundings of the cottage.

While studying in Leipzig, Dr. Preston met Miss Emma Heinrichs, whom, a year later, he brought across the ocean and installed her as the queen of his home. Those who had the good fortune to be admitted to the fireside of our friend were ever impressed with the delightful and charmingly happy conditions created there by the happy harmony of two congenial souls.

But the founder of this ideal home is no more, and we, assembled here to-night, deeply sympathize with the members of the family, left without husband and father. We, as a faculty, mourn the loss of our colleague, whom we admired for his great intellectuality and sound judgment; whom we esteemed for the faithfulness in the performance of duties; whom we cherished for his high integrity; whom we loved for the sake of those noble qualities which brought him close to our hearts.

OCTOBER 14, 1908.

REMARKS OF HON. WILLIAM S. BRYAN AT THE PRESTON MEMORIAL MEETING.

I have listened with interest to what Dr. Preston's medical friends and associates have said about his qualifications as a physician.

That is a subject upon which I would scarcely feel competent, especially in this presence, to express an opinion, although for many years past I have at times had occasion in the trial of causes to avail myself of Dr. Preston's advice and services as a medical expert, and I could not fail to realize that he was a very gifted man.

His manner and methods on the witness stand were well nigh perfect. He was simple, clear, and direct in his language. He used as few technical terms as possible. He contented himself always with fully answering the questions put to him and never attempted to argue the case with counsel. He was always dignified, calm, and frank in his demeanor.

I knew Dr. Preston very well and it is of his qualities as a man that I wish to say a few words.

He was very much interested in improving the condition of those unfortunate persons who are afflicted with mental diseases and he frequently discussed with me questions as to what legislation was desirable in their behalf. His views on this subject were always clear, practicable, and humane.

I frequently talked with him, also, concerning other public questions, and without exaggeration I can say that he always stood for those things which were honest and of good repute.

It is of his social side, however, that I most like to think. He was above everything else a social being. He was very human and loved human companionship. He was kindly and agreeable to a very marked degree. It is impossible to describe in words his social charm, his companionableness, his gentle quaint humor, his fund of new and amusing anecdotes, his flow of animal spirits and his sane and conservative views of men and things.

It was my good fortune to be a member of the same social club with Dr. Preston, and for a long period I met him at the club-house almost every afternoon after the business of the day was over, where with a few congenial friends it was his custom to spend an hour or so in social conversation and relaxation. There was no one of those who there habitually met him who did not look forward to that hour as one of the pleasantest incidents of the day; and they all of them felt when Dr. Preston was taken from us and could no longer be met there, that a distinct personal loss had fallen on them, and that a daily pleasure had gone out of their lives.

The world and the lives of his friends are better and brighter by reason of his having been with us, and his death was a real loss, not only to his friends, but also to the community in which he lived.

REMARKS ON PRESENTATION OF DR. PRESTON'S PORTRAIT.

Dr. Edward N. Brush said that it had been his lot in the past five years to have taken part either in the presentation or acceptance of five portraits of distinguished members of the medical profession.

In four instances the individuals portrayed were living and were present at the exercises connected with the presentations. He was unable to say whether it was more difficult in the presence of the living to say all that one would say without appearing to indulge in fulsome flattery, or on an occasion like the present to express all that was in one's heart and mind concerning a dead friend.

Dr. Preston, Dr. Brush said, was one of the early friends he made when he came to Baltimore seventeen years ago. Dr. Preston had but recently returned from a course of study in the neurological clinics of Paris and Vienna and his conversations were replete with interesting reminiscences of his foreign experiences and his foreign teachers.

Although a neurologist, he was not narrowly or exclusively devoted to pure neurological subjects, but took a broad and intelligent interest in psychiatry.

When about ten years ago Dr. Preston was elected secretary and executive officer of the State Lunacy Commission, he was thrown more intimately and practically into association with Dr. Preston and found him most earnestly enlisted in the cause of lunacy reform in the State, particularly as regards the proper care of the dependent insane, and the establishment of a system of State care. Dr. Preston worked hard to improve the lunacy laws of the State, to advance the standard of care and treatment of the insane in public institutions and has left a lasting impression on the lunacy administration of Maryland.

In the College, his associations with Dr. Preston, Dr. Brush said, had been most pleasant and intimate. The two departments of neurology and psychiatry, as should always be the case, were in most cordial relations with each other, and he found in Dr. Preston a most valuable ally and counsellor.

It had been his privilege to meet Dr. Preston often in consultation, and he had always, even in the rare instances in which their views were not wholly in accord, been impressed by the doctor's diagnostic acumen and accurate and painstaking clinical analysis.

It was possibly on the witness stand, as an expert, that Dr. Preston shone to as great an advantage as anywhere. Never a partisan, he was nevertheless positive in all his statements and ready always to meet the attempts to break down or confuse his testimony in cross-examination. Like many men of his profession, although an admirable witness and one who impressed all who heard him with the honest sincerity of his statements, he disliked to appear in court. This dislike grew out of his strong disinclination to appear in the important position of an expert as in any sense a partisan, an appearance which under our system of employing experts was frequently difficult to avoid.

But a few weeks before Dr. Preston's death Dr. Brush met him in consultation in the city; and as they were walking away from the patient's residence Dr. Preston unfolded his plans for his summer vacation—an ocean voyage and a vacation rest in Europe amid scenes he loved so well. In a few weeks he said in parting: "I shall be on the other side, and shall take a needed rest." Alas! In a few weeks he had passed over to the other side—the long, long rest has come to him—and we his friends are left in sadness to mourn his loss, to listen in vain for a voice that is gone, to long for the touch of a hand that is vanished.

A LETTER FROM DR. PRESTON'S BIRTHPLACE.

By DR. J. J. MCCARTHY, '96.

Every year my business brings me to this pretty town, and though winter has torn aside Lexington's summer array, still the charm and historical surroundings make it a place where the traveler delights to linger.

Its two educational institutions have brought to it much fame and prominence, but it has also clustered around it war memories that are dear to every Southern heart.

It is here that two great commanders of the Confederate army, Lee and Jackson, are sleeping their last sleep.

To us graduates of the College of Physicians and Surgeons, Lexington has much interest. It was here that our beloved Dr. Geo. J. Preston was born, and it was here that he received the education that fitted him to take up the profession and life-work which he graced with dignity and ability. It is here that his mother wrote her famous poems and stories. Margaret Preston's work has placed her in the front rank of American poets.

Elizabeth P. Allan sometime ago published the "Life and Letters of Margaret Preston," and dedicated her book to Dr. Preston's two children, George and Margaret Preston.

It seems that Mrs. Preston was very fond of her two grandchildren. In her letters she refers to them very affectionately indeed.

The evening of her life was spent at her son's home on North Charles St., and in reading over her letters in Miss Allan's book, one is pleased

to note that these golden days were happily spent in the company of her son, his wife and children. What a comfort it must be to this good woman, to be surrounded by her boy and his family.

Dr. Preston's father, Major J. T. L. Preston, was Professor of Latin in the Virginia Military Institute, here, when he won Margaret Preston's hand, and their married life was full of happiness.

Major Preston had been educated at the University of Virginia and at Yale. He and Edgar Allan Poe had been boyhood friends in Richmond, Va., and both learned his Horace out of the same book.

With such parents, how could Dr. Preston be anything but the kind, intellectual man that he was. And as I sat in the hotel lobby to-day my thoughts wandered back to a "little chat" we had some years ago, when he talked to me of Lexington and his school days there.

Let me quote one of his mother's poems:

With faces the dearest in sight,
With a kiss on the lips I love best,
To whisper a tender "good-night,"
And pass to my pillow of rest.

To kneel, all my service complete,
All duties accomplished—and then
To finish my orisons sweet,
With a trustful and joyous "amen."

And softly, when slumber was deep,
Unwarned by a shadow before,
On a halcyon billow of sleep
To float to the thitherward shore.

Without a farewell or a tear,
A sob or a flutter of breath,
Unharmd by the phantom of fear,
To glide through the darkness of death.

Just so would I choose to depart,
Just so let the summons be given,
A quiver—a pause of the heart—
A vision of angels—then Heaven.

His mother died at the doctor's home in Baltimore, March 29, 1897. And, gentle reader, let us picture to ourselves the joyous meeting of mother and son on that thitherward shore that she mentioned in her poem.

CONTUSIONS OF THE ABDOMEN.

BY. DR. A. C. HARRISON, BALTIMORE, MD.

My object in bringing this subject before you is to call attention to a class of cases, the importance of which is frequently overlooked, and in which the average mortality is exceedingly high because of failure to recognize them early.

The caption might well be termed "A plea for prompt exploration when visceral lesion is suspected after injuries of the abdominal region."

Though it is true that within the past few years a number of articles have appeared discussing the general subject of contusions of the abdomen, I am inclined to believe that a general knowledge of the subject is not widely distributed. Every surgeon must frequently be called upon to handle such cases and the urgent need of early operation in cases which have suffered damage to the abdominal viscera, and the great difficulty of differentiating promptly between those which need interference and those which do not, seems to me to warrant an occasional discussion of the subject, before representative bodies, such as are seen at these meetings.

It will be readily recognized that blows upon or about the abdomen are exceedingly common, and that serious damage to the viscera is proportionately rare. However, visceral lesions are common enough, and it behooves us all to watch closely any case that has suffered a severe blow in the abdominal region, just as we have learned to watch closely any case that has suffered a severe head injury, even though there be no important developments immediately after the reception of the injury.

In discussing the results of contusions of the abdomen to the contained viscera, I do not wish to include those organs which are truly classed as pelvic and are rarely seriously damaged, except as the result of crushing injuries producing fractures of the pelvic bones. The rectum and bladder will, therefore, be left out, for convenience sake, though it is true that the bladder is occasionally ruptured as a result of direct force to the abdomen without fracture of the pelvic bones.

There is, of course, the same pressing need of early diagnosis and immediate opening of the abdomen in rupture of the abdominal viscera due to contusions, as there is in perforations due to disease and penetrating wounds. The difference in the attitude of the profession toward the

two conditions is due solely to the difficulties presented in making the diagnosis. It is granted at once that it is sometimes impossible to make a diagnosis by any means short of exploration. It, therefore, becomes an important matter to approach this problem with a proper attitude of mind.

Until recently, I have been inclined to defer opening the abdomen, if after a careful examination of all the evidence in the case, there was a reasonable doubt of the existence of a visceral lesion. After having erred a number of times on this tack, I have come to assume a reverse attitude and now advocate opening the abdomen if I am not reasonably sure that such a lesion does not exist. This I believe to be the correct position, and from this view-point one is much more likely to solve the problem correctly. Even if one errs occasionally and opens the abdomen when no lesions demanding such procedure exists, one is on far safer ground than one who waits for indisputable evidence. The pathognomonic signs, like those of perforations in general, are not those of the primary lesion, but are those of peritonitis, and experience abundantly teaches that to wait for these signs is to wait until all hope of saving the patient's life has passed.

In considering the symptoms of visceral laceration, we must realize that there is no sign nor any group of signs in the early stages that point unerringly to what has happened inside the abdomen after an injury to that region. But a proper consideration of all the possible sources of information and the final arbiter of exploration, will produce the least number of errors, and these few will be the least harmful in their results.

The history of the accident should be gone into with the greatest care, since the type of force applied to the abdomen is frequently of much value, when taken with the clinical picture, in determining the probable results of that force. The kind of force and the region of its application aids in the determination of the viscus most probably injured; thus enabling one to place the opening in the position most advantageous to the manipulation of the injured part. At the same time, we must bear in mind that the local or surface evidences of violence, such as discoloration, laceration, swelling, etc., bear no relation to the amount of damage to the contained viscera. The most serious internal damage may exist without the least external evidence of violence.

Of no less than the degree of force is the manner of its application. A force of much less momentum and greater velocity when applied solidly to the abdomen will often produce greater internal damage than the reverse, when applied in a glancing manner; *e. g.*, horse kicks, man kicks, flying pieces of timber from machinery, etc. Thus, we see the forces most likely to produce rupture are the sudden, sharp blows and heavy crushing forces; the former cause 70 per cent and the latter 30 per cent of all ruptures following contusions. The sudden, sharp blows usually produce single tears, while crushes often produce multiple lacerations. To this list should be added the so-called abdominal concussions, as falls from heights and blows upon the back, in which cases the abdomen may not be struck and yet the same results ensue, but these are the rarer causes, *e. g.*, one of my cases fell from a ladder some fifteen or twenty feet, striking upon his side, and suffered a rupture of the sigmoid; two cases had severe blows in the back and suffered rupture of the liver.

Chevasse notes that of thirty-six horse kicks of the abdomen, thirty-five had rupture of the intestine. Keenan relates twenty-five horse kicks, and of these twenty-four had intestinal ruptures. Of eighty cases of abdominal contusions with visceral lesions, analyzed by Scudder, thirty-six were from horse kicks, twenty-three from carriage-wheel accidents (crushes), thirteen from man kicks, eight from spent shells.

As to the proportion of visceral lacerations occurring in severe contusions, Bryant states that of seventy-one cases, twenty per cent had visceral lesions. As to the seat of rupture; in eighty-nine cases collected by Makins, twenty-one involved the intestine. The same author presents twenty-one cases of his own, and of those, sixteen were in the small intestine. Of one hundred and sixteen cases collected by Curtis, of intestinal rupture, one hundred and twelve were in the small intestine.

Location.—The part of the intestine most often affected is the upper jejunum and the lower ilium, those parts in which is found a movable portion attached to an immovable portion. Multiple rupture occurs in about ten per cent of cases, according to Curtis, other reporters giving much higher proportions of multiple ruptures.

As to the value of the symptomatic signs. There are no early pathognomonic symptoms of rupture of abdominal viscera, and to wait for a sure diagnosis is usually to pass over the time when it is possible to save

your patient. Shock is a variable symptom, ranging in degree from great severity to none at all. It is usually present, however, in more or less degree, and when marked is strongly suggestive. Pain is an almost constant symptom, but bears no proportion to the amount of injury present. Rigidity and immobility of the abdominal wall is a constant symptom and perhaps the most valuable of any single sign, but is often present without visceral lesions, at least of grave degree. When well-marked and persistent, with the history of an injury likely to produce visceral laceration, it, alone, is almost sufficient to warrant opening the abdomen. Hartman relates ten cases of abdominal contusion in which this sign was present, in nine of which visceral lesions were found on operation. One case refused operation and died of intestinal perforation. Tenderness on palpation is nearly always present, but is occasionally absent for a short time after injury. Abdominal distention is a late sign and means peritonitis and ilius. Absence of liver dullness is a late condition and of little value. Dullness in the flanks, of course, indicates fluid, which may be blood, serous exudate, or more probably a combination. When present there are nearly always other symptoms which taken together make the diagnosis fairly sure.

The "facies abdominalis," that indescribable expression, which every one knows, but cannot be put into words, is also a most valuable symptom, and when accompanied with other abdominal signs, should have the gravest consideration.

As to the possibility of a more specialized diagnosis; we must recognize at once that there are no signs by which one may predicate with certainty the exact seat of the lesion, but by the application of all the evidence at hand, one may often guess aright.

If the character of the injury be of the kind likely to produce visceral lesions, located in the epigastric region, with localized pain and rigidity of the recti and possibly free gas in the abdomen, one may surmise rupture of the stomach and place the opening accordingly. Similar circumstances and conditions located in or about the liver region, with evidence of free fluid in the cavity, with progressive weakness, pallor, cold perspiration, restlessness, air hunger, thirst, rapid, weak pulse, rupture of the liver with hemorrhage, may fairly be assumed. A similar train of

events, located in the left upper abdominal and lower thoracic region, rupture of the spleen, etc.

The cardinal points, then, for early diagnosis, are the history of the injury, pain, tenderness, rigidity, facies, shocks, rapid, superficial respiration, palor, and rapid pulse. Any case presenting these symptoms or any considerable combination of them, should be promptly explored, and if we proceed accordingly, many lives will be saved that are now lost. The occasional mistake will do no serious harm, and change a mortality of nearly one hundred per cent, without operation, to that of less than forty per cent with operation.

THE CARE AND TREATMENT OF THE AVERAGE DRUG HABITUE.

BY DR. W. C. ASHWORTH, GREENSBORO, N. C.

There is no branch of medicine or class of patients that appeals to me with such force and interest as the above class of patients. I have for years desired that this class of unfortunates be cared for in a humane manner. I am fully cognizant of the fact that they usually tax the resources of the physician to their utmost capacity. No class of patients makes such demand upon a physician's time and resources as do these patients during their treatment. I have found that drug patients, as a rule, are unusually bright mentally, and that as a class they are nearly always natural mechanics. You seldom find one who is stupid, but on the other hand they are quick thinkers and always on the alert for a new idea and a change from the usual way of doing things. I often find them of much help to me in a mechanical way when things go wrong about the sanitarium. I find they fully appreciate every evidence of an interest in their case and that any attention given them is always fully reciprocated. I take every drug patient with the full understanding that I propose to be his friend all the way through the trying ordeal of the treatment, and that I will give him all the relief that is at all consistent with a cure. My plan of treatment is by the gradual reduction of the amount of the drug used, and in the meantime the administration of strong reconstructive tonics, which enables me to withdraw the drug with the mini-

num amount of discomfort, in fact the discomfort is so slight that the patient is seldom aware when the drug is entirely withdrawn.

I do not approve of the hyoscine treatment, because of its dangerous results, and the fact that I believe there is danger of the drug producing a permanent lesion of the brain. The hallucinations produced by hyoscine are often of the most disagreeable nature, making the confinement of the patient and the constant presence of an attendant necessary.

I find that if the eliminative organs are kept in an active condition and the circulation maintained by the use of proper tonics, the discomfort due to the withdrawal of the drug is slight and of short duration. I have yet to see my first patient that I have found it necessary to give a "knock out" drug. I find the percentage of relapses is smaller if the patient is mentally clear throughout the treatment. When the drug patient leaves the sanitarium realizing that something terrible has happened during his treatment he is much more apt to go back to the drug than if he had been treated in a rational manner, and fully conscious of all that had been done for him, and the relief obtained. Another very important point in the management of these cases is proper dieting.

I have never yet encountered a diarrhoea in a drug patient during the withdrawal of the drug that did not yield to a few doses of bismuth or catechu. This fact I attribute largely to careful dieting throughout the treatment, and especially during the last few days prior to the complete withdrawal of the drug.

I have found that the interrupted electric current from a high frequency machine in the form of a spray over the spine often relieves many of the nondescript aches so often encountered during the withdrawal of the drug. It is here, also, that suggestive therapeutics plays a very important rôle in the management and control of many obstinate symptoms.

In regard to the use of hot baths will say that each case is a law unto itself, and the physician in charge will learn to prescribe them for the class of patients most benefited by their use. All drug patients will be benefited by warm alcoholic rubs and a moderate amount of massage.

In regard to the use of bromides for nervous conditions will say that we have found them entirely useless, their continued use disastrous in effect and clearly contraindicated in a great majority of cases. It is our

plan to teach our patients the futility of depending upon the use of any nervine for support, as its use certainly will make such an impression on the nervous system as will lead to the use of opiates. I have never yet known a drug patient who resorted to the use of alcohol that did not relapse and go back to the use of his former drug.

I expect in another paper to call attention to the duty of the State in behalf of these patients. I see no reason why they should not be cared for as the epileptics of New York and the tubercular of our own State.

UTERINE CARCINOMA.

The readers of the JOURNAL have had their attention repeatedly called to the importance of making an early diagnosis in cases of carcinoma of the uterus. The object at this time is to repeat the same idea and illustrate it with a few cases. Too many of the profession have the idea that carcinoma of the uterus is a hopeless condition and that it makes little difference whether it is discovered early or late in its course. It is true that the course of carcinoma, when not interrupted, runs on to a fatal termination: it has no tendency to spontaneous recovery; and it can be treated successfully only in its early stages. For these reasons it is of the utmost importance that the greatest care and vigilance should be exercised to detect the condition at the earliest possible moment.

No. 810, M. J., age 55, admitted to the City Hospital September 10, 1906. Menses always irregular, occurring a part of the time every two weeks, and accompanied with some pain; duration usually six days. Three years ago the menses stopped.

On July 1, 1906, there was some hemorrhage from the uterus. It was slight at first, but has continued up to the present, and for the past three weeks it has been quite profuse. There has been a dull aching pain in the pelvis since June. She does not think that she has lost any weight.

On examination the uterus was found to be slightly enlarged, not adherent, and in good position. The cervix was soft, slightly dilated and eroded.

September 11, the patient was anesthetised, the cervix dilated and the uterus curetted.

A frozen section of the scrapings showed an adenocarcinoma of the body of the uterus.

September 18, a complete hysterectomy was done.

On examination of the specimen it was found that the enlargement of the uterus was due to several small fibroids, and that the carcinoma had been confined to the mucous membrane of the body.

The convalescence from the operation was rapid; the patient is now in good health, and the probability of a recurrence is very remote.

No. 807, M. J., age 61, admitted to the City Hospital September 6, 1906. Menses stopped at the age of 45. She came in to the hospital on account of vague pelvic pains and gave a history of a chronic cystitis.

Two months before her admission there had been a considerable hemorrhage from the uterus which ceased after a few hours and has not recurred.

September 7 the patient was anesthetised, the bladder was cystoscoped and the uterus curetted. The scrapings were so suspicious that frozen sections were made immediately and a diagnosis of carcinoma was made.

September 11, a complete hysterectomy was done.

Convalescence was rapid.

This patient was examined a few months ago and there were no signs of recurrence at that time.

No. 1215, S. S., age 56, admitted to the City Hospital July 3, 1908. This patient was operated upon for an ovarian tumor four years ago; since that time she has not menstruated.

One month ago she began to bleed from the vagina; at first there was only a slight dribble but a few days before her admission the flow became profuse.

On examination a cauliflower-like mass was found growing from the cervix. A diagnosis of carcinoma of the cervix was made.

July 4, a complete hysterectomy was done.

The patient left the hospital July 21, and has been in good health since, but the time has been too short to tell anything about the probability of recurrence.

On account of the character of the growth, the prognosis is less favorable in this case than in either of the preceding.

No. 1073, H. J., age 48, admitted to the City Hospital November 18, 1907.

This patient had never ceased menstruating, but for the past year her periods had come on every two or three weeks and had been profuse and prolonged. In May the flow continued for the whole month. More recently much pelvic pain had developed, and there was trouble in passing water.

On examination the outline of the external os could be made out, but the cervix was much enlarged.

November 19. Under anesthesia the enlarged cervix was found to be a shell filled with a mass of carcinoma; the growth extended upward into the uterus and invaded the broad ligaments. The curette and cautery were used, but it was not considered advisable to attempt to do a radical operation.

These cases all illustrate the importance of investigating the cause of uterine hemorrhage. The first, second and third cases show that when the cause of the hemorrhage is looked into with a reasonable degree of promptness, and its cause found to be carcinoma, the patient is usually still in a condition that offers hope of permanent relief. The fourth case is one of a large group that shows the disastrous results of attempting to treat these cases without making a diagnosis.

When a woman over forty bleeds from the uterus, don't tell her that it is due to the change of life and give her some medicine; but first investigate the cause of the hemorrhage.

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

STATE BOARD EXAMINATION QUESTIONS.

It will probably be a long time before the State Board examinations will be given in any other method than that of a set of written questions and answers; and whilst this method is certainly open to many objections, we must all recognize that certainly for the present, it is going to be the means of testing the applicant's knowledge of medicine and fitness to practice. A certain amount of study, therefore, of the questions asked by the State Board examiners is not out of place, and many times when a teacher, or some one familiar with this subject from a practical standpoint, reads the examination questions propounded by some of the State Boards, they marvel much, not that many applicants fail, but that so many manage to pass the examinations successfully. If any one familiar with the subjects on which the Boards examine will take up many of the State Board questions, they will find that to answer them correctly it involves a knowledge not often possessed by men who are perfectly familiar with medicine from a practical standpoint. The examinations should be so arranged as to cover the subject to the satisfaction of the examiner, but it should also be so arranged that the applicant may be able to express in his answers his knowledge of the subject. This means that catch questions, questions dealing with special parts of subjects which a student might overlook, and similar questions, should be avoided. A very good plan followed by some States is to give fifteen questions and

allow the applicant to choose either five or ten of them. In this way a much fairer idea of what the applicant knows can be arrived at than by giving five or ten questions, all of which are to be answered, as it not infrequently happens that one or more questions may touch on a part of a subject with which the student is unfamiliar. Questions of very technical nature, which a man in practice would probably look up in a book before using, should also be avoided. It is unfair for an examiner to assume special knowledge, say of chemical tests. A man working in a laboratory for two or three years might possess this, but the frequency with which even these workers refer to their text-books for special tests should be a lesson to the examiner to avoid such pitfalls. In chemistry, in pathology and materia medica, the questions are liable to be obscure and misleading, and it may be difficult sometimes to determine what the correct answer to a question would be. For example, "What is a sago spleen?" or, "Under what circumstances is ozone found?" or, "Describe the preparation and state the uses of cyanogen." In materia medica and therapeutics, questions are often asked which the student ought not to be expected to answer. For example, "Name two galactogogues." We should be glad indeed to know of one of any practical value. Obsolete, or rare drugs, often those which are not official, are included in the examinations. For example, questions about picrotoxin, which most of the text books either do not mention at all or give a few lines concerning it. The drug is not official and certainly a medical student should not be examined on unofficial remedies. Many of the official remedies of questionable value are not taught in medical schools, and ought not to be if they are. We confess to having referred to certain drugs and preparations in the course in therapeutics only for the purpose of warning the student that the State Board examiners often ask questions concerning certain drugs which in the present state of our knowledge are best avoided. Conium and phytolacca may be mentioned as examples of these.

It would be difficult indeed to suggest any means by which State Boards could be prevented from asking questions which are unfair to the applicant. There are too many different opinions on this and other points for us to hope to secure anything like uniformity, and especially with the present method of appointing or electing examining boards. But much

could be done if, when unfair questions are asked, the examiner and the Board had their attention called to the fact by members of the profession; and the members of the Board should remember that they are, in a large measure, responsible for all the questions asked, and when one examiner propounds questions that are unsuitable, the other members should feel it their duty to see that these are omitted. It will probably happen eventually that the examinations and licenses to practice medicine may be made national instead of State affairs, but this is not liable to happen in our day, and any help or improvement that can come to our present method will certainly be welcomed.

PRESTON MEMORIAL MEETING.

The meeting in memory of Dr. Preston was held in the College amphitheater on Wednesday, October 14, 1908, at 8.30 p. m. Professor C. F. Bevan acted as chairman. An oil painting of Dr. Preston was presented to the faculty of the College on behalf of the students, by the president of the graduating class, Mr. Causey. This was followed by an address by Dr. Wm. Simon, on "Preston as Man and Friend." Dr. E. N. Brush spoke on "Preston as Scientist and Physician," and Dr. Standish McCleary on "Preston as Teacher." This was followed by remarks by the Hon. Wm. Sheppard Bryan, who spoke on the social side of Dr. Preston and of his medico-legal abilities. In another place will be found some of the addresses made on this occasion.

Obituary.

DR. EZRA M. SELLERS, '93, died October 22 at his home in St. Marys, W. Va., from injuries received in an automobile accident a few days before, aged 42.

DR. HENRY STUART CROCKETT, '72, a member of the Medical Association of Georgia, of Americus, Ga., and assistant physician in the State Hospital for the Insane, Staunton, Va., from 1882 to 1884, died in the City Hospital at Americus, September 8, aged 61.

DR. MARK P. PERRY, '84, formerly of Macon, N. C., a member of the Medical Society of the State of North Carolina, and for six years its treasurer, the head of a hospital in Richwood, W. Va., died in Johns Hopkins Hospital, Baltimore, November 9, aged 40.

DR. HARRY M. RODGERS, '84, a member of the Medical Society of Virginia, a member of the Virginia House of Delegates for six years, and a popular practitioner of Rockingham County, Va., died at his home in Mount Crawford, October 3, from nephritis, aged 48.

DR. EDWARD HARRIS JOHNSON, '69, of Troy, Ala., a member of the Medical Association of the State of Alabama, and a Confederate veteran, local surgeon for the Atlantic Coast Line, was struck by a train while making a professional call, August 27, and died a short time later, aged 63.

Personal Notes.

DR. R. S. GRIFFITH, '86, of Basic City, Va., has been elected president of the Augusta County Medical Society. At the same meeting, Dr. H. Wellard, '99, was elected a member of the same society.

DR. A. S. PRIDDY, '86, of Marion, Virginia, has been compelled to resign his position as superintendent of the Southwestern Virginia Hospital, and it is to be hoped that his retiring from active duties for a while will result in the full recovery of his health, and that he will be able to enter the ranks as a private practitioner in the near future.

DR. W. T. AYERS, '86, is doing missionary work in China. He has charge of the Warren Memorial Hospital, Hwanghiên. During the past year they had an attendance of 10,319 patients in the hospital and dispensary. The hospital work is in connection with the Southern Baptist Mission.

DR. WILLIAM J. TODD, '88, transmitted to us a copy of the resolutions passed at a recent meeting of the Baltimore County Medical Society

upon the occasion of the death of Dr. George J. Preston. The limited space of the JOURNAL prevents the printing of many similar sets of resolutions.

Marriages.

DR. ALFRED ULLMAN was married to MISS BERTHA KATZ Thursday, November 12, at Honesdale, Pa. They will reside in Baltimore City, on North Broadway.

DR. ERNEST FRANKLIN SMITH was married to MISS LIDA PRICE TROY Thursday afternoon, October 1, 1908, at the Methodist Episcopal Church in Centreville, Maryland.

DR. GLENN M. LITSINGER was married to MISS FRANCIS CORDELIA CHILDS on Tuesday, November 10, 1908, at 12 o'clock, at the First Methodist Episcopal Church in Baltimore.

Correspondence.

HUNTINGTON, W. VA., June 27, 1908.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find check for \$2.00 for subscription for the JOURNAL. I am ashamed of myself that I have neglected this so long. I was sorely disappointed that I was unable to attend the reunion of the class of '79, as I had looked forward to that time with much pleasure, and sent Dr. Cole the assessment some days before. But I have a "liver," and it vetoed the act. I suppose those who were so fortunate as to be present enjoyed all things to their full measure. I would have appreciated a program of the affair. With best wishes for you and yours, and hoping that the college, with all those connected with it, may continue to prosper, I am,

Fraternally yours,

THOS. F. STUART, '79.

WHEELING, W. VA., June 30, 1908.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find check for payment of JOURNAL for '07 and '08.

P. and S. is certainly having tough luck with losing all its old stand-byes such as Trimble, Latimer and now Preston.

I expect to take my vacation soon and will try and get down to the old school and see some of the boys.

We here of course have gone through the financial crisis, as well as others, but the P. and S. boys are all still on top.

Yours very truly,

G. L. VIEWEG.

STAMFORD, N. Y., June 26, 1908.

CHARLES EMIL BRACK, M. D., Baltimore, Md.

My Dear Brack.—Enclosed find \$2.00 for ALUMNI JOURNAL, as per bill enclosed. You must begin to think me dead, inasmuch as it has been two years since I have written. Being a member of class of '95—your own—it is particularly negligent on my part. I assure you, however, I often think of you all, and still hope to reunite with my class in this world. Am very busy professionally and otherwise, and have no fault to find with fate in her dealings.

Faternally yours,

JOHN E. SAFFORD, '95.

PITTSBURG, PA., August 22, '08.

CHAS. E. BRACK, M. D., Baltimore, Md.

Dear Doctor.—Enclosed please find check for \$2.00 in payment for the JOURNAL of 1908 and 1909.

In the future direct the JOURNAL to 1135 Greenfield Ave., Pittsburg, Pa., 23d Ward.

Hoping this will find you well and prosperous, and that the JOURNAL will continue to be the success that it has been in the past, I am,

Yours,

O. C. HAGMEIER, '06.

HOPEWELL, N. J., June 30, 1908.

Dear Doctor.—Enclosed please find my check in payment of the subscription to the JOURNAL. I am getting along very well in Jersey.

Yours,

T. A. PIERSON, '94.

NEW YORK CITY, July 22, 1908.

DR. CHAS. E. BRACK, Baltimore, Md.

My Dear Doctor.—Enclosed find \$5.00 for three years' arrears of the JOURNAL; for the balance credit me on my subscription for the JOURNAL.

It was with deep regret I read of the death of Profs. Latimer, Trimble, and Preston. May the teachings of these great men bear fruit among our alumni.

I am located in New York City, and have been very successful, as follows: (a) Am doing nicely in private practice; (b) Hold a position as lecturer in materia medica at the Fordham University, School of Medicine; (c) Am connected with the health department of this city, having been appointed after passing a competitive examination.

With best wishes for all connected with the C. P. and S. and my classmates of 1905, I remain,

Yours sincerely,

F. C. SCHUMACHER.

JERSEY CITY, N. J., July 17, 1908.

Dear Doctor.—Enclosed find \$2 for JOURNAL, etc.

How are my old friends, Drs. Dobbin, Gardner, and not forgetting Litsinger?

Am very busy at present with obstetrics; otherwise, Jersey is slow.

Will write more later. Regards to all.

Yours,

S. A. REICH, '02.

CALAHAN, N. C., July 1, 1908.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—The picture taken the night of our reunion is at hand. Enclosed please find one dollar, for which send me the JOURNAL and receive my kindest regards.

Yours respectfully,

J. M. CAIN.

NATIONAL CITY, CAL., June 30, 1908.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor Brack.—Enclosed please find \$3.00 to balance ALUMNI JOURNAL account. Had hoped to call on you before this, but did not make it. Please remember me to the old friends. Have been in California for past two years. Closed out my practice in Nebraska.

Truly,

H. J. ARNOLD, M. D., '89-'90.

MT. CLAIR, W. VA., July 26, 1908.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Received last JOURNAL, which was forwarded me here. Was glad to see account of our commencement written up so nicely. Was successful with my State Board Examinations, and am now practicing here, doing contract work. Two of us here have seven coal mines to look after, besides some country practice. We have all kinds of ailments around the mines, and I consider this good experience for a young fellow just out of school. It is almost as good as a year in a hospital, and it is more lucrative besides. Am sending a year's subscription for JOURNAL, and any time have any interesting cases would be glad to write the same up for you. With best wishes for the college and faculty, I am,

Yours sincerely,

W. T. OWENS.

EL PASO, TEXAS, August 14, 1908.

My Dear Doctor Brack.—Enclosed you will find my subscription for the ALUMNI JOURNAL. I have been in El Paso just a year and like the place more each day. Am on the visiting surgical staff of both hospitals, and manage to get my share of the work; also assistant surgeon to one of the largest railroads running in here. I expect to spend three months next summer in the east doing post-graduate work. With my best regards for all at the old school, not forgetting yourself, I am,

Yours sincerely,

FRENCH S. CARY, '06.

SALT LAKE CITY, July 2, 1908.

CHAS. E. BRACK, M. D., Baltimore, Md.

My Dear Doctor.—For the last year I have not seen a single issue of the ALUMNI JOURNAL; the reason why I cannot explain, but such is the case. Please find enclosed my check for one year's subscription and kindly address the JOURNAL to me at 304-305 The Sharon Bldg., Salt Lake City, Utah. Give my kind regards to all the boys and tell them that I am getting along nicely. Have been sporting an automobile for two years, and at present am building a beautiful \$10,000 home.

Yours very truly,

ROSS ANDERSON.

JARAD, W. VA., August 8, 1908.

Dear Doctor Brack.—I am enclosing you my check for \$1.00 for the subscription to the JOURNAL. I get a sample copy now and then, and the last number reminds me of days long past. I refer to the meeting of the class of '79 and the fact that Professor Bevan was the only one of the old faculty left. I am a member of the class of '83, and Dr. Branham was my preceptor; and of the faculty at that time only Drs. Bevan and

Simon remain. My old and much loved friend, Dr. Chambers, was demonstrator of anatomy at that time. I should like very much to see a reunion of the class of '83, but I am afraid that there would be a great many missing from the line which received their diplomas at the Academy of Music. At this commencement Professor Gundry took the place of the famous orator, Vorhees, who was to have been the orator, and at the last moment missed his train. With only two hours preparation, Professor Gundry gave us a talk which I have never forgotten. I have never had the pleasure of meeting you, although we both belong to the same Alumni Association, and I hope that when the class of '83 meets, to shake your hand.

Yours fraternally,

CHARLES W. SPANGLER.

VIRGINIA SANATORIUM FOR CONSUMPTIVES.

IRONVILLE, BEDFORD Co., VA., November 26, 1908.

DR. CHARLES E. BRACK, Baltimore, Md.

Dear Dr. Brack.—After successfully operating upon and assisting in the disposal of a quartette of nicely browned turkeys, stuffed with fine Chesapeake Bay oysters, with the addition of a few large Virginia chestnuts, to give the proper flavor, I decided to indulge myself to the extent of a pleasant little chat with you regarding some of the old mutual friends and the numerous class reunions spoken of so much of late in the JOURNAL.

I have of late often wondered what has ever become of my old chum and class-mate, Dr. T. S. Lowe. I would like very much to learn of his whereabouts and how he is getting along, so if it lies in your power, will you kindly send me his address?

Dr. Ranzely, who at one time attended the old P. & S., is, I understand, engaged in practice at Christiansburg, Va., a short distance from me; so far, however, it has not been my pleasure to meet him.

From the number of articles on the subject appearing in the JOURNAL of late, it appears that nearly all of the classes are endeavoring to hold,

at some time in the near future, class meetings. Now, while I would enjoy very much attending a meeting of the class of '97, if there is to be a meeting of several classes in the near future, why can't we make it an alumni reunion, so that we may have the pleasure of meeting each other and forming, if possible, a stronger bond of union between the graduates of the dear old school.

It has been my good fortune to have been in nearly all, indeed, I can say all, of the states and territories of our Union, and I have found in nearly every one of them, a graduate of our College, and in the majority of instances he would be a stranger to me. How very much nicer it would be, therefore, to arrange an alumni reunion and meet and get acquainted with each other.

It might be possible to form a fraternity of some nature between the graduates of our College, as is the case in many of the literary colleges, something similar to the old Bacillus Club, which flourished along in the years of '95, '96, and '97, which I am sure would a source of great pleasure and advantage to many of us.

I have been the resident medical superintendent of this institution for some little time, but now that the state is going to establish a similar one, this one may be merged into the new one, in which case I am going to endeavor to secure a similar position with the new institution. My work here has been eminently satisfactory to the board of directors in every way and I will have their hearty endorsement in my efforts towards the appointment in the new institution. The results of our treatments here will compare very favorably with that of any similar institution anywhere in this country, and in the majority of cases we are far ahead.

Well, I must close for this time, but will let you hear from me at some time in the near future; please insert this letter in the JOURNAL so that it may meet the eye of all of the boys and give them an opportunity to express their views on the subject of an alumni reunion.

With kindest regards to all of the boys and all of my professors there, I beg to remain,

Sincerely and fraternally yours,

DR. J. MEADE WHITE, '97.

NEW LONDON, CONN., October 23, 1908.

DR. CHAS. F. BEVAN.

Dear Doctor.—Just a few lines to inform you that I have received notice from the New York State Board that I have been successful in my examinations. I know it would be pleasing to you to learn the same.

In the course of the next few weeks I intend to open an office in Flatbush, L. I., which is a suburb of Brooklyn. If, at any time, I may be of service to you or to the College, you may feel sure I shall be glad to do anything that may lie in my power. I wish you, and the College in general, every success in the present year and those to come. Believe me to be,

Most sincerely yours,

JOHN T. LEAHY, '08.

GREENVILLE, S. C., November 2, 1908.

DR. C. E. BRACK, Baltimore, Md.

My Dear Doctor.—I have just received the October number of the JOURNAL. I desire to know if there has ever been a reunion of the class of '77. I am a member of said class, and while it has been 31 years ago, I would like to once more meet some of my old class-mates. See if we can't get a reunion next commencement. Dr. Shields, of West Virginia, was president of the class. Dr. Gombrell, or Gombell, was also a member. Dr. Crocroft, Dr. Hines, and about thirty others were among the number. Dr. Chas. B. Scull, of Florida, and Dr. Shull, of Pennsylvania, were my room-mates. I should like to correspond with some of the class about a reunion.

My address is G. L. Martin, M. D., Greenville, S. C. Ask any member who may be alive now to write to me and let us get up a reunion in 1909, for we are all now getting along in life. Thanking you in advance for any efforts you may make to get up a meeting in 1909, I am,

Truly yours,

G. L. MARTIN, M. D.

P. S.—Would like to hear from Dr. Scull, of Florida, and Dr. Shull, of Pennsylvania.—G. L. M.

GLOUSTER, OHIO, November 9, 1908.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Brack.—Enclosed you will find check for three dollars in payment for subscription to JOURNAL. I have just been elected coroner of Athens County, on the Republican ticket, by a large plurality.

Dr. F. W. Davis, of 1905, has been with me one month. He likes the work and the place; we have formed a partnership and everything is running smoothly.

With kindest regards to all, I am,

Yours truly,

DR. J. G. BLOWER, '05.

GILBOA, N. Y., November 10, 1908.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor.—Find enclosed check to pay up for years 1907 and 1908; should have done this before, but being busy, have neglected it. Am glad to receive the JOURNAL, each time, and hope I may be able to accompany my old preceptor, Dr. J. S. Robinson, of Kingston, N. Y., class '84, to Baltimore at the class reunion of the class of '84.

Yours fraternally,

E. S. PERSONS.

REMEDIOS, PORTO RICO, November 7, 1908.

DR. CHARLES E. BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find check of one dollar for the JOURNAL, in payment of subscription for 1909.

I enjoy the JOURNAL very much and I find it a very nice medical paper. I was very sorry when I heard of the death of Drs. I. R. Trimble and of Dr. Preston; they both were very wise teachers.

Best regards to you and the faculty.

Yours truly,

O. DE CATURLA.

LETART, W. VA., November 12, 1908.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor Brack.—Enclosed find money-order for two dollars for JOURNAL. I am located at Letart, W. Va., and getting along very well. Give my regards to Ralph and Lawrence Quillen. With best wishes to P. & S., I remain,

Yours truly,

D. V. SMITH.

McKEESPORT, PA., October 30, 1908.

Dear Doctor Brack.—Enclosed find check for two dollars for JOURNAL.

I noticed in the July number that the class of '79 held a reunion. How delighted I would be if we could have a reunion of my class, which is '83. The changes that have taken place in twenty-five years are many. Dr. Bevan is the only active man of our faculty doing college work. I believe I am right about that.

I can never forget our dear old professors. What an influence for good they exerted on our lives!

I am located at McKeesport, Pa., about twelve miles from Pittsburg. With the exception of about eight months, I have been here ever since graduating. With best wishes for everyone connected with the P. & S., I am,

Very truly yours,

H. S. NEWLIN.

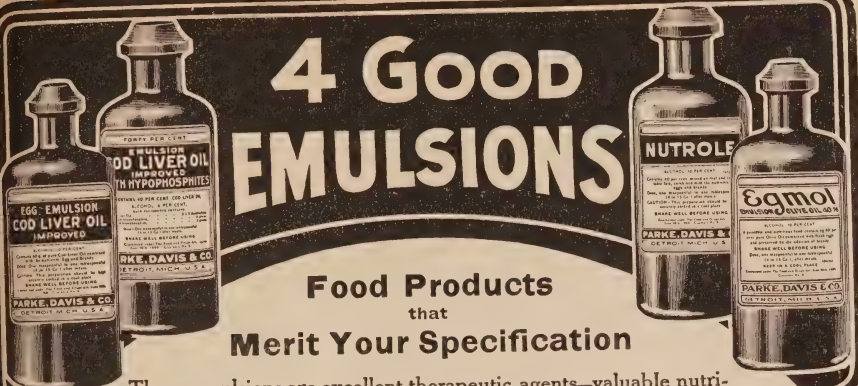
SCRANTON, PA., October 30, 1908.

DR. C. E. BRACK.

My Dear Doctor.—The JOURNAL for October is just at hand, for which accept thanks. I enjoy hearing from the boys, and look with pleasant anticipation to the arrival of the JOURNAL. With best wishes to all the boys, but especially the class of '79, I remain,

Very truly,

THOS. W. KAY.



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Vol. XII

No. 1

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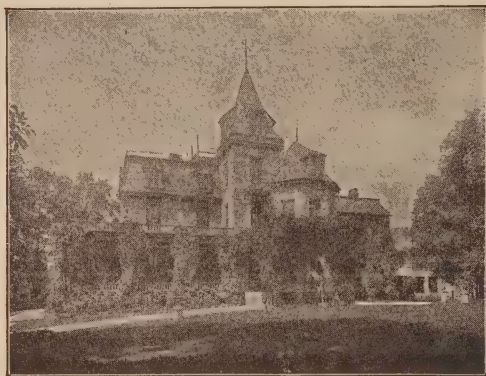
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By DR. W. SIMON.

Color photography, for years the dream of the photographer, the scientist and the artist, became a reality on the day on which the Lumière autochromatic plate was presented to the world; this occurred in the late summer of 1907.

Previous to that time—for twenty years or more—the discovery of various methods for taking photographs in natural colors had been announced from time to time; but, while of great interest scientifically, none of these methods was at all suitable for the requirements of the amateur or professional photographer. Indeed, people had been disappointed so often that they had lost faith in the ultimate solution of the problem and were rather skeptical when once more the announcement was made, that at last the goal had been reached. And yet the claim was justified, for the reason that a method had been placed at our disposal which would enable anyone, familiar with ordinary processes of photography, to make an exposure of an object, and within an hour hold in his hand the true image showing every tint and shade of the object photographed.

The name of the man who accomplished this happy result has long and favorably been known to the photographic world as that of an ingenious inventor and a successful manufacturer of photographic appliances. It was Monsieur Antoine Lumière, of France, and it was more especially his

* A lecture delivered before the members of the American Chemical Society and their ladies during the Baltimore meeting, December, 1908.

two sons, Auguste and Louis, who after a series of scientific experiments extending over a period of 15 years, succeeded in placing on the market an autochromatic, *i. e.*, a self-coloring photographic plate.

It is the object of this article, first, to refer briefly to the scientific principles which rendered possible the invention, then to describe the nature and manufacture of the plate, and finally, to explain the changes which it undergoes from the time the exposure is made to the enchanting moment when the image gradually appears to the eye of the operator in the charms of truthful coloring.

The various methods employed in color photography may be divided into two classes, *viz.*, direct methods, which attempt the formation of a colored image from colorless material; and indirect methods, which use coloring agents in conjunction with the photographic process. The Lumière method belongs to the second class and the successful manufacture of the autochrome plate is the outcome of the application of a few well-known facts relating to the nature of light and color.

At the outset we should remember that there is no such thing as color in an objective sense. Color is a sensation—a something supplied by our minds; it is not an inherent property of matter, any more that heat is a property of the stove, or light of the electric lamp. Not until a fire is started and heat waves strike the stove, or the current is turned on and electric waves pass through the filament, do we notice the effects of heat and light; and not until light waves strike an object which reflects them to the retina of our eye do we experience the sensation of color. Consequently, whenever we seek to record color, we attempt to record something that does not exist outside of our own minds. Apart from our brains the beautiful colors and gorgeous tints are simply oscillations of the ether. The frequency of the oscillations, as they strike the retina of the eye, determines the color we see.

But the color of a substance is not a fixed quantity; it varies with and depends upon the light acting on the object. For present purposes it is sufficient to consider the action of ordinary white light, or daylight. Of this we know that it is made up of variously colored lights which are generally designated as the spectrum colors, or rainbow colors. While seven of these colors (red, orange, yellow, green, blue, indigo, violet) are differentiated it has long been shown that there are but three primary

colors, viz., red, green and blue, which by overlapping produce the intermediate colors of the spectrum. And in a peculiar way these three primary colors under the influence of more or less illumination also produce the thousands of tints and shades in nature. This is brought about by the different behavior of the various substances toward light. Scientifically, we say that when light strikes an object it is either all absorbed or all reflected, or partly absorbed and partly reflected.

Whenever a surface absorbs all the light so that nothing passes from it to the eye, we call the object black. Whenever all the light is reflected so that the retina of the eye is subjected to the simultaneous action—we might call it a bombardment—of red, green and blue light waves, we have the effect of white. When part of the light is absorbed and another part reflected, we experience a color effect corresponding to the action of the reflected portion, whatever that may be, red or green or blue—or a mixture of two or of all three of them in any proportion whatever.

While our anatomical and physiological knowledge of the eye does not justify a full explanation of the manner in which the sensation of color is transmitted, yet it has been suggested that there are in the retina three sets of nerve terminals, each set sensitive to the waves of one of the three primary colors.

Here a word should be said regarding the terms “tints” and “shades,” which are often used incorrectly. The term *tint* (or *hue*) signifies any variety of color depending upon the proportionate mixture of primary colors but independent of intensity. Tints depend upon the respective *proportion* in which the three nerve terminals of the human eye are affected. The term *shade* refers to the degree of luminosity and depends on the *intensity* with which the light waves act on the eye. The more intense the action the brighter the color effect; a decrease in intensity does not change the tint but imparts a darker shade. Decrease in intensity may be due to the interception of the rays of light, as in shadows, or to the decrease of luminosity in the source of light, as when the sun goes down. The gradual darkening of tints is equivalent to an admixture of black, and the darkest shade of any tint—even of white—is black.

To summarize: All colors apparent in nature are the result of the action on the human eye of three kinds of light waves which individually produce the sensation of red, green or blue. When acting simultaneously

in a definite proportion they produce white. When otherwise mixed various *tints* result; while darker *shades* are due to a decrease in intensity of light, which decrease culminates in black, *i. e.*, the complete absence of light waves.

Ordinary photography gives a record of the intensity of light, *i. e.*, of shades, but neglects tints, *i. e.*, color. Any attempt to produce a true color image of an object must fail unless light waves identical in kind and intensity with those waves which are reflected from the original are made to pass from the image to the eye. And this is precisely what the Lumière method accomplishes in a most ingenious way.

Before describing how this is done, it should be mentioned that a transparent colored medium (for instance, a colored glass) will permit light of its own color only to pass through. This means that through a red glass plate nothing will pass but red light; and consequently if white light strikes a red glass the latter prevents the passage of the green and blue rays, contained in the white light, while the red light passes through. The corresponding rule holds good for green or blue glass. The peculiar effects produced in the appearance of an object or a landscape when looked at through colored glass are due to this action.

The fact that the three primary colors, when acting simultaneously on the eye, produce white, can be demonstrated in different ways. For instance, we can decompose a beam of white light by causing it to strike a prism; and by collecting the band of prismatic colors thereby formed, on another prism standing in a reverse position, we obtain white light. Again, alternating stripes of red, green and blue may be painted on a disk and the disk be caused to rotate quickly, when the surface appears white. Or highly diluted solutions of suitable red, green and blue dyes may be mixed in such proportions that a colorless liquid is obtained.

The same result may be accomplished by yet another method, which has a more direct bearing on the Lumière method. It is this: Whenever the surface of a panel or a plate is covered with minute dots of the primary colors in such close proximity as to give the appearance of mosaic work, then the individual color particles will be seen close by. But on stepping back from the panel, the bright colors gradually merge into a grayish and finally an almost white surface.

The explanation is obvious: Close by, the colored dots act individually

on the nerve terminals, but from a distance there is combined action, and white results. If on such a mosaic panel all the green and blue dots should be painted black, then, close by, the red dots will be seen imbedded in black, while at a distance the plate will show a bright red color, the black not being noticeable at all. Or if only the green dots were painted black the plate from a distance would show as wholly crimson, resulting from the combined action of the red and blue rays on the eye.

The facts so far stated have long been considered by scientists as a possible means for color-photography. The most successful efforts were those which led to the well-known three-color process, of which a few words should be said because it was the forerunner of the Lumière method.

In the three-color process three photographs are taken of the same object, through three glass plates (called ray-filters or color-screens) tinted with the primary colors; that is, three photographs are taken through red, green and blue glasses respectively. From the facts stated heretofore, it is evident that in taking a photograph through red glass, only the red light emitted from the scene or object can pass to the photographic plate, while all other rays are eliminated, and thus a photographic record is secured of all that is red in the view. The same holds good for the views taken through green and blue "filters."

Let us assume that a photograph is taken of a mass of flowers—red roses, blue violets and green leaves. On photographing through a red glass, the plate when developed will show little more than the roses, because the green and blue light could not penetrate the red glass. Similarly the photographs taken through the green and blue filters will show chiefly the leaves and violets respectively. However, it should be remembered that no rose, no violet, indeed no object in nature is found which shows but one primary color; consequently there are found on the respective plates, alongside of the well-defined chief objects, also more or less pronounced images of the other parts.

Many attempts were made to utilize these plates, or the prints made from them (both of which, of course, are black), for color work. They have been used, for instance, as lantern slides in a triple stereopticon; three projecting cameras being arranged in such a manner that the images thrown on the curtain will be superimposed precisely one over another. When the views are projected through glass of the same color as that

which served as a color screen for the photographs, viz., through red, green and blue glass, respectively, each picture contributes the requisite proportion of the color recorded in it, and the reconstruction in color of the object photographed is accomplished.

The most extensive use made of the three-color process is in color-printing. Here, three printing plates are made from the three photographic plates; and by printing from them, one over another, with red, green and blue transparent dyes or inks,¹ a truthful color reproduction is obtained; but it is a print and not a photograph.

Recognizing the shortcomings of the three-color process scientists have been engaged for many years in attempts to utilize the three-color principle as the basis for a more satisfactory method for color photography. Some of these efforts were not without success, but the most brilliant example of the application of the three-color principle is the method evolved by Lumière.

The ingenious part of this process lies in the fact that the colored particles which are first utilized as a color-screen through which the photograph is taken, serve afterwards as the medium, giving color to the finished image.

The manufacture of the Lumière autochrome plate is accomplished in the following manner: Portions of starch are colored intensely red, green and blue by means of dyes carefully selected to correspond to the primary colors. The starch granules employed are so small that approximately two thousand of them must be laid side by side in a row to take up one inch of length; and it takes over four millions of them to cover one square inch of surface.

A mixture of these colored granules is dusted over a glass plate, covered with some sticky material in such a manner that the granules are imbedded close together and yet do not overlap. The mechanical difficulties in the way of accomplishing this task have greatly taxed the skill of the inventors, and it has required years of patient work to finally solve the problem.

After the starch granules adhering to the plate are flattened out by a roller so that no light can pass through the plate save as it penetrates

¹ Usually yellow, red and blue inks, and in addition often also a black ink, are used for reasons not necessary to explain here.

these granules, it is given a coating of varnish so as to prevent the photographic solutions from reaching the starch granules during development of the exposed plate.

Over the varnished plate a coating of sensitized silver emulsion, such as is used in other rapid-acting panchromatic photographic plates, is placed; and the plate is now ready for use.

From the description of the process of manufacture of the autochrome plate, it is evident that it is a photographic plate so arranged that a layer of microscopically small, transparent granules, tinted in the primary colors, is placed between the glass plate and the sensitized silver salt.

If the coating of sensitive silver emulsion is removed, the plate shows a nearly white surface, because the colored granules are so small that individually they make no impression on the eye; but when the plate is examined under the microscope the intensely colored starch particles are seen as a mosaic surface.

The conversion of this mosaic plate into a color photograph is accomplished by a process similar (in principle at least) to the one used by that sculptor who, in answer to the question as to how he converted a block of marble into a work of art, said that this was simply done by cutting away the portions of marble not forming a part of the statue.

Similarly, on the autochrome plate there are eliminated (*i. e.*, rendered black) completely or partially the granules which do not enter into the formation of the image, while those granules are laid bare or rendered visible which form the picture. But while the sculptor accomplishes his task with the chisel, the formation of the color image is brought about entirely by chemical means.

In making an exposure with an ordinary plate, its sensitized surface is directed toward the object, while the autochrome plate is reversed, being placed so that the glass surface is toward the object to be photographed. On making an exposure in the camera the light reflected from the object passes through the lens, then through the glass plate, next filters through the starch granules and, after having passed through this color screen, strikes and affects the sensitive silver salt. The exposed plate is next taken to the dark room and developed with a suitable developer under precautions which need not be mentioned here. "Developing" means the conversion of that portion of the white silver bromide which had

been acted on by light into permanent black metallic silver. Remembering that light waves could not strike the silver salt without having passed through the colored starch grains, it follows that the red, green and blue light passing through these grains, could only act upon silver bromide particles behind granules of the same color.

For instance, the light from a red flower would pass chiefly through a mass of red granules, striking the silver salt behind them, but leaving more or less intact the silver salt behind the green and blue granules. Consequently, in developing the plate, only that silver bromide which lies back of the granules which permitted the passage of light is converted into metallic silver. This silver deposit is thinner or thicker in proportion to the intensity of the light.

Upon examining the developed plate (with the aid of a specially prepared dark-room lamp) it is found not to differ much from an ordinary negative. But when examined microscopically it is seen that the image of silver is not homogeneous but consists of millions of individual black dots of various density, hiding more or less completely the color granules underneath.

The plate after having been developed (two and a half minutes is the time generally required) is next placed in an acidified solution of potassium permanganate which has the power to dissolve completely every particle of the photographically reduced or metallic silver. The plate can now be taken from the dark room, and upon holding it against the light, there is seen upon its surface the transparent image of the object photographed in natural colors.

The explanation is simple enough: Wherever red or green or blue light has passed through starch granules of the same color, there was formed a silver deposit which was in turn removed by dissolving it, and consequently, the underlying starch granules, previously hidden by opaque silver bromide, have been laid bare more or less completely and have been rendered visible in transmitted light.

At this stage of the process the picture lacks in strength; *i. e.*, the light colors are deficient in brightness and the dark ones lack in intensity. The reason is that there is yet left on the plate all that silver bromide which had not been acted on when the exposure was made.

It was pointed out before that the three primary colors produce *tints*,

while the *shades* are the result of a more or less intense light action equivalent to an admixture of more or less black. This black has yet to be supplied in order to obtain an image correct also in shades.

The task is easily accomplished by exposing the plate to light and developing it a second time, when all the white silver bromide yet left is converted into more or less transparent black silver. This second development of an autochrome plate is practically identical with the formation of a positive image in black and white, and serves to expose or hide the colored granules in a ratio corresponding precisely to the intensity of the light.

Photographs on glass are often tinted with transparent dyes, as for instance in making colored lantern slides. The finished autochrome picture is practically a black silver image tinted by transparent colored starch granules with a fidelity true to nature and far superior to anything that can be accomplished by the hand of man.

From the nature of the Lumière method it is seen that each exposure furnishes but a single autochrome photograph as a transparency on glass. There is as yet no satisfactory process known for printing them on paper. But even if this could be done the print could never equal the original in beauty and strength of color, for the reason that a print is seen by reflected and an autochrome by transmitted light, unless it is used in the stereopticon for projection so that the image is reflected from a curtain, when, however, it loses much of its charm.

The most satisfactory way of seeing an autochrome is to place it on a ground-glass plate with a sufficiently strong white light behind it, and look at it through a large (say an eight-inch) magnifying glass. The life-like appearance of the picture is then marvelous.

In a former paragraph it was stated that a true image of an object could only be obtained in case the kind and intensity of the light waves passing from the image to the eye were identical with those reflected from the original. Paintings in oil or water colors, in many cases at least, can not possibly solve this problem, because while the artist may select the right color tint, he has no means to control intensity. The difference in the intensity of illumination between high lights and deep shadows as found in nature may be a dozen times greater than that which the artist can produce even when using his most extreme means, white and black.

The best painted sunset, for instance, is a poor makeshift for what we see in nature, simply because the artist has no color which will send out rays of light equal in intensity to those of a setting sun and the nearby clouds.

All this is different in an autochrome photograph which is the result of a process that registers to a nicety both the tints and the intensity of the light waves in such a way that, when seen under proper conditions, light waves identical in kind and intensity with those of the original pass to our eye. That such should have been rendered possible is another triumph of the age in which we live.

REPORT OF ONE SURGICAL SERVICE OF THE BALTIMORE CITY HOSPITAL FOR THE SUMMER OF 1908.

By DR. ALEXIUS McGLANNAN, '95.

The public patients admitted to the surgical wards of the City Hospital are assigned to one of three divisions of the surgical service, according to the day of the week on which the patient enters. All the public-ward patients coming into the hospital on Wednesday and Thursday are under the care of Dr. Bevan. From June 1 to October 1, 1908, through the kindness of Dr. Bevan, I had charge of this division.¹

Probably the most persistent memory of the hospital held by our alumni is the impression of the tremendous number of injured people treated there. For this reason a word of explanation is required to make clear the character of the lesions recorded in this report. The accident room is more busy than ever and the accident service is as great as heretofore, but the present laws and agitation concerning employers' liability have brought it about that all this class of cases come into the hospital as private patients of the surgeon, who is engaged by the large factories and works, or by casualty insurance companies themselves. For this reason the report here published does not represent one third of the work done in the hospital, and it further explains the absence of any number of the most common causes of admission.

¹ The cases of laceration of the brain, of extra-uterine pregnancy and the gun-shot wound of the femoral vessels were referred to me by Dr. A. C. Harrison, who is in charge of another division of the service.

The total number of patients treated was 64. Of these, 4 died, one was unimproved, 3 were improved, and 56 were cured. Since October 1, I have followed as many as possible of these patients. Of the improved cases, one patient, with an abscess of the prostate, died 4 months later of general tuberculosis, 2 months after the removal of a tuberculous left kidney. The unimproved case, a patient admitted with an inoperable carcinoma involving the parotid, tonsil and jaw, died during October of general carcinosis.

The following is a summary of the more important cases, classified according to the lesion treated, with some comment on their interesting features:

Abdomen.—Appendicitis, 8 cases: Acute appendicitis, 4 cases; chronic, 2 cases; abscess, 2 cases—all cured. Tubercular peritonitis, 2 cases—one died, one improved. Tubal abortion, 1 case—cured. Pyosalpinx, 1 case—cured. Intestinal obstruction, 2 cases—2 died. Hernia, 4 cases: Indirect inguinal, 1 case; recurrent inguinal, 1 case; post-operative, 2 cases. Varicocele, enlarged inguinal rings, 2 cases. Adenitis, cervical tuberculous, 4 cases; pyogenic, 2 cases: inguinal pyogenic, 1 case; saphenous pyogenic, 1 case.

Wounds, Infected.—Carbuncle, 1 case—cured. Leg ulcer, general septicemia, 1 case—died. Hand, 1 case—cured. Scrotum, 1 case—cured. *Gun-shot*, chest wall, 1 case—cured; femoral vessels, 1 case—cured.

Genito-urinary.—Urethra, stricture, 2 cases—cured. Prostate, benign hypertrophy, 1 case—cured; abscess, tuberculosis, 1 case—improved. Cystitis, 1 case—cured. Hydrocele, 1 case—cured.

Fractures.—Jaw, lower, 1 case—cured. Colles, 2 cases—cured. Fore-arm, 1 case—cured. Tuberosity of humerus, 1 case—cured. Pelvis, 1 case—cured. Neck of femur, 1 case—cured. Shaft of femur, 1 case—cured. Tibia and fibula (compound), 1 case—cured. Fibula, 1 case—cured.

Brain.—Laceration with sub-dural hemorrhage, 1 case—cured. Reported in detail.²

Appendicitis.—The appendix was removed in all the operations. The abscess cases were drained, but the peritoneum was closed in all the

² Military Surgeon, December, 1908.

others. In the four acute cases there was cloudy fluid in the peritoneal cavity, but no wall of granulation tissue, and so the absence of this tissue decided against drainage. In these patients a small protective drain was carried down to the fascia, in order to drain the fat layer of the abdominal wall. Fat is a tissue of extremely low resistance, and this fluid from the peritoneum in such lesions always contains many bacteria. The consequent infection of the fat is very likely to cause abscess formation unless drainage is provided for during the first 48 hours. The protective drain should always be taken out at the end of this time and the wound allowed to close. The average duration of the patients' stay in the hospital was 12 days; the longest, 2 weeks; the shortest, 10 days. All went home healed.

The cases of chronic appendicitis were not at all unusual. In all a McBurney muscle-splitting operation was done, the appendix removed after ligation with catgut, the stump disinfected with phenol and alcohol and turned in by a purse-string suture of fine silk. Both patients made uninterrupted recoveries and left the hospital on the 14th day.

The abscess cases of course were drained. Iodoform gauze and protective cigarette drains, and iodoform gauze alone were used. The drains were started about the 5th day, and all the gauze taken out of the wound before the 14th day. One of these patients went home healed completely on the 29th day. The other patient had a sinus that persisted for 68 days, due to an infected silk ligature in the fat. Neither patient at this time has any evidence of hernia. The silk sinus in the second case shows the great advantage of catgut sutures and ligatures in suppurating wounds.

Extra-uterine Pregnancy.—One case. This patient was a young negro who had suffered with symptoms resembling recurrent appendicitis for several months. There was no interference with menstruation. She was taken with sudden very severe colic, with rigidity and muscle spasm of the entire abdomen. When admitted to the hospital 12 hours after the onset of these symptoms, she had the abdominal signs of a perforative peritonitis of a severe type. The abdomen was opened without attempting a more definite diagnosis than that the trouble originated in the right lower quadrant. As soon as we got into the peritoneal cavity the great hemorrhage present determined the diagnosis. The tube was quickly

brought up and clamped and also the broad ligament was similarly treated. The ruptured tube was removed and the blood clots wiped out. As there was a good deal of raw peritoneum we decided to put in a cigarette drain to the pelvis. The wound was closed and the patient made an uneventful recovery.

Pyosalpinx, with Symptoms of Intestinal Obstruction.—The condition here resembled that described by Murphy⁸ In these cases the ileus was both infective and reflex and the symptoms of obstruction masked the real cause of the trouble. Twisting of the pedicle of the tube adds a great deal to the severity of the symptoms, and gives the signs of a diffuse rather than of a localized peritonitis.

The patient was a young negress who had the clinical symptoms of intestinal obstruction of 12 hours' duration at the time of admission. The leucocyte count was 22,000, rather less than one would expect in acute obstruction occurring in an individual with good resistance. No definite diagnosis was made, but it rested between ruptured appendix, pus tubes, and extra-uterine pregnancy. Immediate laparotomy was done and the condition was recognized at once. The tubes were removed and the wound closed without drainage. The patient made an uninterrupted recovery and left the hospital cured, on the 19th day.

THE AFTER-TREATMENT OF ABDOMINAL OPERATIONS is a very important subject, and when properly carried out aids materially in the patient's recovery, and at the same time adds greatly to his comfort. For this reason I will give in some detail the methods we have used for this purpose. In carrying out these methods I was most skilfully assisted by the resident surgeons of the hospital, and especially by Dr. Petros, the assistant resident surgeon, on duty with this service, who was untiring in his zealous attention to all these details.

I. *The Position of the Patient.*—The upright position, popularly called Fowler's, was brought into prominence as an adjunct in the cure of suppurative peritonitis. Its great value was said to depend on the flow of the pus into the pelvis, where the absorption is less rapid. Observing a number of very ill patients treated in this position, we noticed that these individuals were more comfortable during convalescence than those who

⁸ Kelly and Noble's Gyn. and Abdom. Surgery, Vol. II, pp. 395 and 404.

were less ill at the beginning and were treated in recumbency. We, therefore, began to put all the abdominal cases, except the hernias, in this position at once, and found that the patients were much more comfortable. This greater comfort is in a measure due to the gravitating of the intestines from the diaphragm, and further, to the freer use of the arms and shoulders permitted.

II. *Proctolysis*.—The administration of salt solution slowly by the rectum, introduced by Murphy (Surg. Gyn. and Obs., June, 1908), is one of the most valuable aids in after-treatment. Properly administered the solution is absorbed about as fast as it flows in; consequently there is no accumulation and therefore no rectal distress. It is possible to give several thousand cc. in 24 hours without discomfort. The absorption of this fluid assists in elimination of the ether, and lessens the post-operative nausea. There is little or no thirst, and the dilution of the toxins of infected cases materially diminishes the danger of fatal toxæmia. We made it a rule to give 500 cc. to every patient who had ether for any purpose, and in the abdominal operations gave it continuously for the first 24 hours. The success of the salt-solution therapy depends entirely on the method of administration. Much care is required in order that the flow may be slow enough, that the pressure may be just sufficient, and that the position of the tube in the rectum may be such that no pressure is made on the wall of the bowel.

III. *Lavage*.—One of the most serious of the sequelæ of any operation is an acute dilatation of the stomach. When the abdomen has been opened, and especially when there is inflammatory disease or much handling of the intestine has been required, the frequency of this complication is greatly increased. The condition is rapidly fatal if untreated; consequently it is to be guarded against, watched for, and promptly relieved. Fortunately the use of the stomach tube and lavage will cure the condition, if used in time. The stomach of every patient who continued to vomit longer than 12 hours after anæsthesia was washed out. Whenever a patient vomited green or brown material the stomach was at once washed until the water returned clear, and the washing was repeated whenever the vomiting recurred. By this method we believe we have checked oncoming acute dilatation. In one of the cases of acute appendicitis, with diffuse in-

jection of the peritoneum and a large quantity of cloudy fluid free in the cavity, I am convinced that the frequent stomach washings in the first 36 hours were of great importance in securing the good recovery.

IV. *Eserine Salicylate*.—This drug is of value in the treatment of post-operative adynamic ileus. Combined with lavage and enemas it is a most efficient agent in the treatment of this group of cases. The usual dose is $1/32$ grain hypodermically, repeated in 2 hours if necessary. A rectal tube should be inserted beyond the sphincter about half an hour after each dose and allowed to remain for the same length of time. While the rectal tube is in the bowel the proctolysis must be discontinued. The prophylactic use of this drug was suggested to me by Dr. Preble, late resident surgeon of St. Agnes Hospital. He studied its action in a number of cases and felt that this was a valuable use of the remedy. We gave $1/64$ - to $1/32$ -grain doses, immediately after the patient left the table, in all cases where much distention was present, or where the bowels had been manipulated to any great degree.

Occasionally eserine produces syncope, which may be quite severe. For this reason it is well to give it with a small dose of strychnine to patients whose blood pressure is low.

The usual directions for using this drug advise against its use in cases of suspected mechanical obstruction. When the patient is in the hospital and the surgeon is prepared to do enterostomy on short notice, a dose of eserine is a valuable aid in diagnosis in doubtful cases, because it intensifies all the symptoms and clears away the doubt.

V. *Sparteïn Sulphate*.—Post-operative anuria is occasionally noticed in septic peritonitis as well as in other conditions. The rectal salt solution usually overcomes this, but patients, while retaining large quantities of salt solution, may have inactive kidneys. In some cases the retention of fluid may be so great as to cause pulmonary œdema.⁴ Here sparteïn sulphate in $\frac{1}{2}$ - to 2-gr. doses, as recommended by Stuart McGuire,⁵ is practically specific, and even in the anuria due to preexisting nephritis.

VI. *Morphine*.—Much controversy has raged over the value of morphine in post-operative treatment generally. At the 1908 meeting of the

⁴ Bulletin of Med Chi. Faculty, November, 1908, p. 92.

⁵ Proceedings of Southern Surg. and Gyn. Assn., 1906.

American Surgical Association, Deaver's opinion that morphine should never be given in peritonitis was opposed by many men of equal prominence. In our experience morphine judiciously administered in small doses, from 1/16 to 1/10 grain, is useful. The general tendency is to give larger doses, and this unnecessary narcotization leads to the unpleasant effects—namely distention and vomiting.

Intestinal Obstruction.—Two cases, both fatal. To the surgeon, so constantly on the lookout for the signs of mechanical obstruction, the apparent apathy of many practitioners in the face of these dangerous symptoms is startling. Not only is the condition frequently overlooked, but even when it is recognized, the injudicious use of purgatives intensifies the distress of the patient and delays surgical intervention until the time for cure has passed.

The danger of obstruction increases as the point of constriction approaches the stomach, and is greatly intensified by the rapidity with which the bowel is occluded. Maury's very valuable experimental work on this subject has been published in part.⁶ A very good study of the clinical course, pathology and treatment will be found in Bloodgood's articles.⁷

The importance of early diagnosis and prompt treatment becomes apparent when we review statistics that show almost 100 per cent mortality in all cases of high acute obstruction that have persisted over 48 hours. Enterostomy, often multiple enterostomy, will be required in most cases of over 24 hours' duration.

One of our cases was a sigmoid obstruction of six days' duration, due to pressure of the bowel between a retro-peritoneal lymph cyst and a bound-down mass of inflamed tubes, ovaries and uterus. The patient was a negress, forty years of age, who had been drenched with purgatives to exhaustion, and who died on the table.

The other case was a child obstructed for a week by an intussusception of the ileum, who died four hours after operation.

Tubercular Peritonitis.—Both cases were of the hyperplastic variety with little fluid. Both gave general and local reactions to the diagnostic injection of tuberculin, and in both pieces of peritoneum removed at operation showed tubercles grossly and on microscopic examination.

⁶ *Annals of Surg.*, October, 1907, p. 556.

⁷ *Johns Hopkins Hospital Bulletin*, August, 1907; *Annals of Surg.*, November, 1907, and February, 1909.

In one patient the disease was clearly of appendicial origin and an attempt was made to remove the appendix. This attempt necessitated so much stripping of the bowel that it was abandoned and the wound drained. Later a fecal fistula developed in the wound and the patient died on the 21st day, apparently of inanition.

The other patient was closed tightly after exploration and treated with Wright's opsonins. He left the hospital on the 88th day, much improved. He had gained greatly in weight and was free from abdominal discomfort.

Hernia.—The modern Halsted operation without transplantation of the cord was done for both inguinal hernias. The post-operative cases were large openings through the rectus, and considerable dissection and a muscle plastic operation were required in each case to close the gap.

Gun-shot Wound of the Femoral Vessels.—The bullet entered through the fascia lata and was felt in a hæmatoma in the upper part of Scarpa's triangle. This was opened and the vessels exposed, strong pressure with sponges being used to control the hemorrhage. An attempt was made to suture the wounds in the artery and vein, but the walls had become so friable that the sutures cut out at once. Therefore the vessels were doubly ligated in the wound and the track of the bullet disinfected and drained. There was anæsthesia of the foot for 10 days. The superficial veins became dilated, but did not remain so permanently. The patient left the hospital cured.

Genito-urinary.—Both strictures were impermeable, and were treated by perineal section and excision. Perineal prostatectomy by Young's conservative method was done for the benign hypertrophy. The sac of the hydrocele was excised.

Fractures.—Colles fractures were reduced under ether and put up with the anterior, posterior and lateral pads. The fractured hip was treated by the Whitman fixation in abduction.

The carbuncle was completely excised under ether. The infected hand was treated with Bier's constriction hyperæmia and small incisions.

The Alumni Association has selected and recommended as headquarters for the American Medical Association meeting Hotel Poinsettia, corner of Boardwalk and Ocean Avenue, Atlantic City. Rates are \$2.50 per day and upward, on the American plan; \$1.50 per day and upward on the European plan.

A NEW MEDICAL CHART.

BY DR. H. M. COHEN, '96.

As Dr. Bevan truthfully remarked in moving a rising vote of thanks to Dr. James J. Walsh at the conclusion of his lecture on the History of Medicine in the Thirteenth Century, it was certainly one of the most enjoyable evenings the P. and S. Medical Society has ever experienced.

History at its best is a dry sort of topic, but when we get an opportunity to listen to a fluent speaker who knows his subject and at the same time is able to present it as a living, breathing thing, we are indeed fortunate. The President, Dr. Mitchell, put it aptly in introducing the speaker, when he quoted Lord Macaulay's trenchant and truthful remark to the effect that history should be brought to the level of the novel. If that is true with the story of nations and peoples, it is even more so when the subject is that of the history of medicine. Dr. Walsh, in his characteristically easy manner, brought the dry facts of the long dead past to our notice with all the fascination of the most interesting novelist.

But does not Dr. Walsh rather overestimate the medical greatness of the thirteenth century? I am inclined to think that if we take away from it the still burning embers of the teachings of Hippocrates and Galen, we shall find little that stamps it above mediocrity. The great school at Salerno was already sinking into senility, and the universities of Montpellier and Naples had hardly yet thoroughly illumined the horizon. Razes and Avicenna had lived and taught in the twelfth century, and Arabian medicine had reached its highest point contemporaneously with them.

* * * * * * * *

Of course, the thirteenth-century doctors seem to have done more than their share of discussion. But let the reader try and recall the names or works of any one of them if he can. To make use of an Irish bull, the only really great doctor of the period that comes to our mind was Roger Bacon, and he wasn't a doctor. He did have the superiority looked for in epochal characters but he got a lot of persecution for his pains. The clergy did not like his views on things, and made life as miserable as they could for him. They had just recently been interdicted from practicing medicine by the Council of Montpellier and did not relish it.

They let go only after a struggle, but ultimately the medical men won out. It was not the Emmanuel movement then, but we may rest assured it was something equally plausible. Does it not seem rather remarkable that notwithstanding the fact that it is taught us that a certain place is always overflowing with sinners, there have always been men of the cloth who could spare time from the work of salvation to heal the sick! The greatest event of the twelfth and thirteenth centuries from the medical standpoint was the edict of Montpellier. Let us hope that the present-day doctors will be able to ultimately explain to certain of our good brothers that Shakespeare was a wise man in his generation when he advised a certain maker of footwear to stick to his last.

* * * * *

Some of these days I intend to take a temperature chart and mark off the degrees of advance and decline of medical knowledge as found in the history of medicine. I shall start, of course, with Hippocrates, the father of medicine, way up somewhere near the breaking-point of the thermometer, and gently remiss for several centuries down grade through Aristotle, the first of a long line of medical *dilettanti*: Theophrastus, the founder of botany; Herophilus, the champion bleeder; Erasistratus, who was the first to break away from the teaching of Hippocrates; and Philinus, the founder of the Empiric school. Then I shall begin an exacerbation through Asclepiades, the friend of Cicero, and on to Themison, whom I will favor with a full stop because he introduced the use of leeches in medicine, and was innocently instrumental in giving us the same for a nickname ever since. Next will come another slide for a few lines to Soranus, and of course he deserves a pretty big dot because he proved to be the first and last man in history who felt himself really capable of getting up a reliable work on women.

Here we shall rise and fall for a while until we get to bottom, when we shall have to start on another ascent. I expect we shall have to go well up this time, for the next station will be called Dioscorides, named for the man who built the first valuable pharmacopea, and who transmitted to us the names and uses of opium, squill, asafetida, ammonia and castor-oil. He started the first century A. D., and it must be admitted that his friends have stuck by us faithfully ever since.

But up we continue until we are once again near the hyperpyrexia point, which we mark with Galen. He was a Greek who went to Rome, but found that the Romans were too busy making material for Shakespeare's plays. So he wiled away his waiting period wrestling with the boys as a pastime. It seems that although he himself belonged to the light-weight class, he tried it on with a heavy-weight, who, probably not knowing the place his opponent would occupy some day in history, had the hardihood to throw him. He did this so effectually that Galen's arm was dislocated by the fall. Our hero established a precedent by reducing it himself, without the aid of an outsider. Anyone who could perform such a stunt could become almost anything, so we are not surprised to find him placed on the highest line of our chart with Hippocrates. He brings us through the third century, where we shall let him rest in peace.

And now comes another slide. Our line, on its descent, pierces Oribasius, the friend of Emperor Julian, the Apostate. His Royal Highness was a great believer in putting things up to the oracle at Daphne, and one day sent his medical friend over to get some advance tips. Oribasius came back with the tale that the oracle had given him to understand that it was not longer in the prophesying business. Things went pretty hard with Julian after that, but that is another story. We are more interested to know that Oribasius stuck to the fallen monarch, and followed him into exile among the barbarians, from where he was finally recalled and treated more kindly.

Our line drops a little to stop at Aetius, the court physician at Constantinople, who distinguished himself in the sixth century principally in separating the parotid and submaxillary glands; down a little more, through Alexander of Tralles, the first Eclectic; and up a space or two to Paulus Aegineta, who in the seventh century got up, probably, the first work on obstetrics.

Our course leads us now down again and the chart shows a rather monotonous clinging to the border. In the tenth century the Arabians monopolized the healing art and the mercury line therefore takes a sharp turn upward.

Razes is the first stop, for he was so great that he was sent for by his king, to whom he had dedicated his great work on medicine, and was rewarded by a pretty large purse of gold. The royal man was much pleased

with the book and scrutinized it most carefully. Like a real good Arabian, Razes had gone over most minutely the exact directions for turning a base metal into gold by use of certain chemical agents and arts, and the king was so greatly impressed with Razes' discovery, that he commanded the wise physician to go through the process for his especial benefit. Of course, Razes was only too honored to favor his king, but really, there were so many agents required that it would be difficult to gather them together then and there. "But thou shalt have every thing thou needst, my physician, even though all my subjects are put at your service." Razes hem'd and haw'd, and alas! *en fin* declared that he had promised more than he could fulfill, and the king, it is said, grew exceeding wroth, and hit the unfortunate doctor man in the region of the inferior maxilla! This happened in the reign of Al Munsur, the Caliph of Bagdad.

Up the mercury still climbs, and the next stopping-place is for Avicenna, no doubt the greatest man of Arabian medicine. He too is well on toward the hyperpyrexia line. He was not only a great physician but a jolly good fellow as well. He had a great following, and was very likely the most popular teacher that ever handed out knowledge to thirsting students. However, it is said that their thirst was fully quenched when the lessons of the day were over, for then he put aside his austerity with his canon, in came a bevy of dancing girls, on come a cask of wine, and the dull hours of the afternoon were dissipated in hilarity. Who would not study medicine under such a master? But Avicenna, with it all, was no doubt among our very greatest medical heroes.

* * * * *

But from this high point our line takes a most threatening tumble. In fact, the temperature become dangerously subnormal, and I am afraid that, to continue my chart, I shall have to bring in poor old Roger Bacon, who, though not a medical man, will serve as a dose of strychnia and keep us going long enough to reach the point that we shall mark for Linacre, who established the London Royal College of Physicians in the sixteenth century.

A little higher up we shall put in a mark for Caius, the founder of Caius College, Cambridge; and up still more for Sylvius, who discovered the fissure and aqueduct of that name; and yet up to Vesalius, who was

such an ardent student of anatomy, but had such a hard time getting dissecting material, that he found it necessary to steal a body from the gallows to satisfy his craving for that kind of work. He opposed Galen in his teaching and was at loggerheads with Bartholomew Eustachi, the describer of the Eustachian tube. Here we must pass our line through Gabrielle Fallopius, who a student once declared had been named after the Fallopian tubes. History has some nasty things to say about our friend Gabrielle, among which is that story about his poisoning a criminal so as to get a chance to dissect him, and at first not having succeeded he tried, tried again.

Our line now must take a sudden jump for one of our great unique characters, Paracelsus by name. He was a real top-notch but his confrères would not or could not see it. He fed his patients on mercury and his rivals called him and his followers quacks because of their plentiful use of quicksilver, which in German is called quacksalber, and for brevity was amputated to quack; and we have been using the same term ever since to designate the fellow who does not play the game according to Hoyle.

I find that my blank chart is not broad enough to continue, so I shall have to begin my second with a zigzag line which will take us down and up through Stahl, who tried to unravel the mystery of the soul; Hoffman, the mechanical philosopher; and Boerhaave, of whom it was said that a letter directed to him simply addressed "Boerhaave, Europe," would reach its destination. Peter the Great once spent the entire night on a barge near Boerhaave's office so that he could consult him two hours before lecture time the next morning.

Up we now go with our line to Albert Haller, the "Father of Physiology," which brings us to the early part of the eighteenth century, and William Cullen, the author of the famous Cullen's *Materia Medica*; and his one-time secretary, John Brown, that brainy but eccentric leader of the "Brunonians." His teaching has long since been forgotten, but his wit is still worth laughing over. In his early days he held a position as tutor to a young Berwickshire laird. Even in that early period he was strong on stimulants, and one night, having somewhat overindulged, he was ordered up to his room. It happened that the laird was entertaining

a number of his friends and neighbors, and after dinner the guests entered upon a discussion of the theological question of the Decrees of Providence. They could come to no conclusion and it was decided to leave the decision to young Brown. A servant was accordingly sent upstairs, with the master's compliments, to learn what Brown thought of the Decrees of Providence. The reply came quickly: "Tell the laird I think the Decrees of Providence very absurd that make so many blockheads lairds." Brown lost his job. The principal American Brunonian was Benjamin Rush, who cleared up an epidemic of yellow fever in Philadelphia, and later became one of the signers of the Declaration of Independence.

Once more our temperature line shows a rather sudden and marked exacerbation and Wm. Harvey appears on the scene. His discovery of the circulation made him one of our greatest benefactors, and from him there is the slightest descent to Sydenham, the great common-sense physician who first made use of quinine in his practice. His colleagues ridiculed him for advocating it, but he converted the almost universal malaria into an occasional happening and therefore did not suffer for the lack of encouragement.

And now begins another zigzag down and up through Hahneman, the founder of homeopathy; Jenner, the discoverer of vaccination; Auenbrugger and Laennec, who introduced percussion and auscultation; Richard Bright, whose name is attached to one of the kidney inflammations; Thomas Addison, of Addison's-disease fame; John Hunter, who gave to us Hunter's canal; and James Y. Simpson, the discoverer of the anæsthetic effect of chloroform; and in our own day, ———.

I should have to begin on another blank if I thought it wise to go on. But I think the curves already outlined are sufficient to make the diagnosis easy. As Dr. Walsh has intimated, the history of medicine does not show a continuous exacerbation. But let us hope that our days are making a change for the better.

LIST OF PHYSICIANS OF THE CLASS OF '85, COLLEGE OF P.
& S., WHO HAVE EXPRESSED THEMSELVES IN FAVOR
OF A CLASS REUNION.

Dr. F. W. Larison, Lambertville, N. J.; Dr. A. J. Campbell, Middletown, Conn.; Dr. J. H. Fietz, Lambertville, N. J.; Dr. W. Beverley West, Fort Worth, Texas; Dr. G. Franklin Bell, Williamsport, Pa.; Dr. J. W. Johnston, Clarksburg, W. Va.; Dr. D. C. Hurst, Washington, D. C.; Dr. James T. Hurd, Galetton, Pa.; Dr. W. M. Lyday, Penrose, N. C.; Dr. P. R. Hardee, Stein, N. C.; Dr. J. B. H. Knight, Williamstown, N. C.; Dr. Robert G. O'Hara, Bedford City, Va.; Dr. H. J. Patterson, Portland, Me.; Dr. J. B. Colcord, Port Allegany, Pa.; Dr. N. W. Stallard, Dungannon, Va.; Dr. C. W. Birdsall, Hyattsville, Md.; Dr. E. L. Wilkinson, Dorranceton, Pa.; Dr. Orion Baum, Vine, Va.; Dr. Thomas W. Brockbank, Germantown, Philadelphia, Pa.; Dr. John M. Crook, Columbus, Ga.; Dr. John U. Pickel, Baltimore, Md.; Dr. Frank C. Bressler, Baltimore, Md.; Dr. A. S. Grimm, St. Marys, W. Va.; Dr. J. H. Ray, Coalton, O.; Dr. John H. Devor, Chambersburg, Pa.; Dr. L. Gibbons Smart, Lutherville, Md.; Dr. Edwin B. Ferebee, Raleigh, N. C.; Dr. George H. Witter, Wellsville, N. Y.; Dr. W. B. Goley, Graham, N. C.; Dr. G. W. Cocke, Danville, Va.; Dr. J. I. Coleman, Hurdle Mills, N. C.; Henry W. Wandless, New York City; Dr. D. H. Barker, Palestine, W. Va.; Dr. William S. Gardner, Baltimore, Md.; Dr. J. R. Flanagan, Syracuse, N. Y.; Dr. B. D. Evans, Greystone Park, N. J.

We hope to have a large representation from the Class of '85 at this reunion. The alumni meeting, commencement and banquet will be on the evenings of June first and second. The date for the reunion, coming just before the meeting of the American Medical Association at Atlantic City, is fortunate.

Dr. Britton D. Evans, Greystone Park, N. J., has done much work to make the reunion a success. Dr. William S. Gardner, 6 W. Preston St., will assist him in the local arrangements.

WILLIAM S. GARDNER, M. D., EDITOR,
6 W. Preston Street.

JOHN RUHRÄH, M. D., ASSOCIATE EDITOR.
839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., BUSINESS MANAGER,
500 E. Twentieth St.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

COMMENCEMENT ANNOUNCEMENT.

The Annual Meeting of the Alumni Association will be held at the College Tuesday, June 1, at 8.30 p. m. Addresses will be made by Dr. Samuel T. Darling of Ancon Hospital, Panama, and by Dr. Christopher C. Hersman of Pittsburg, Pa.

The Commencement will be held at Albaugh's Theater Tuesday, June 2, at 8.00 p. m. The oration will be delivered by The Reverend Arthur B. Kinsolving.

The Alumni Banquet will be at the Belvedere immediately after the close of the Commencement exercises. Toastmaster, Dr. Robert E. Lee Hall, '84.

Members who will attend the Banquet are requested to notify Dr. Chas. E. Brack, 500 E. 20th Street, not later than noon, Tuesday, June 1. Members of the Class of '85 are requested to send their names to Dr. William S. Gardner, 6 W. Preston Street.

A TESTIMONIAL TO DR. KEIRLE.

It is with great pleasure that we announce that a testimonial volume consisting of the collected published writings of Dr. N. G. Keirle will be published by a committee consisting of Drs. Harry Friedenwald, J. W.

Chambers and A. C. Harrison. The book will also contain a sketch of Dr. Keirle's life and work and his portrait. Dr. Keirle has been intimately connected with the college and its work for many years, and his being personally known to every student who has studied under him makes this volume especially welcome.

Dr. Keirle's great work in connection with the subject of hydrophobia will be given due prominence, and the volume will be of interest not only in that it is about Dr. Keirle, but also for its real scientific value, as it will contain practically all the information needed on the subject upon which he has devoted his life's work.

The subscription to the volume is \$5.00, and each subscriber will receive a copy and one will be sent to every medical library in this country and to the principal ones abroad. Any of the alumni who wish to subscribe toward the publication of this volume are requested to communicate with Dr. Harry Friedenwald, 1029 Madison Ave., Baltimore, Md.

Obituary.

DR. JOSEPH H. LEIB, '79, died suddenly at his home in Mount Pleasant, March 3, from angina pectoris, aged 57.

DR. JOHN A. SCHULTE, '75, of East Baltimore, died at the home of his brother in Baltimore, February 20, aged 56.

DR. LUTHER L. CHAMBLIN, Baltimore, '78, died at his home near Philomont, Va., December 2, from paralysis, aged 53.

DR. J. HARRY FORBES, '03, of Pawtucket, R. I., died at the Twin City Hospital in that city, on January 24. Death was due to a gun-shot wound.

DR. JOHN G. DUCKWORTH, '75, a member of the South Carolina Medical Association, died at his home near Anderson, S. C., from cerebral hemorrhage, February 10, aged about 60.

DR. ERASTUS L. WILSON, '89, physician to the town of Lisbon, Maine, formerly a practitioner of Howard, R. I., died suddenly while making a professional call in Durham, Maine, March 1.

DR. JOSEPH LAVENDER LAXTON, Washington University, '68, a member of the Medical Society of North Carolina, and a Confederate veteran, died at his home in Morganton, November 11, from acute gastritis, aged 73.

DR. JOHN B. BASS, '70, a member of the American Medical Association and of the board of U. S. pensioning examining surgeons of St. Clair county, Ala., a Confederate veteran, died at his home in Ashville, February 21, aged 64.

DR. JAMES WILLIAM TANKARD, Washington University, '69, a member of the American Medical Association, and for 35 years a practitioner of Lillian, Va., died in the University Hospital, Baltimore, December 31, five days after an operation for abscess of the liver, aged 62.

DR. JOSEPH HARRIS STONESTREET, '85, a member of the Medical and Chirurgical Faculty of Maryland, school commissioner of Montgomery county, and local surgeon for the Baltimore and Ohio Railroad, died at his home in Barnesville, January 13, from pneumonia, aged 48.

DR. FRANCIS MARION MORGAN, Washington University, '69, a Confederate veteran, physician to the Norfolk county jail, ward physician of Berkley and coroner for several terms, formerly surgeon to the Norfolk and Southern Road, and health officer of Portsmouth, Berkley and Brambleton, died at his home in Norfolk, Va., December 25, aged 63.

DR. WILLIAM NEVIN HILL, Washington University, '74, of Baltimore, a member of the Medical and Chirurgical Faculty of Maryland, well-known on account of his efforts to exterminate the mosquito and to reclaim the swamp lands of Maryland, secretary of the National Drainage Congress, died at the Sheppard and Enoch Pratt Hospital, near Towson, Md., from brain tumor, December 25, aged 51.

Personal Notes.

DR. A. S. PRIDDY, '86, of Keysville, Va., is a member of the State Medical Examining Board of Va.

DR. T. McLARNEY, '97, was lately appointed visiting dermatologist to St. Francis Hospital, Waterbury, Conn.

DR. T. D. McDONALD, '04, is assistant physician at the Manhattan State Hospital, Ward's Island, N. Y.

DR. G. F. SARGENT, '03, has been appointed assistant physician of the Florida Hospital for the Insane, Tallahassee.

PROF. J. W. CHAMBERS, '78, and DR. S. M. FREE, '80, Du Bois, Pa., have recently returned from a visit to St. Paul, Rochester and Chicago.

At the annual meeting of the State Board of Health, held January 16, '09, DR. W. ROYAL STOKES was reappointed bacteriologist, and DR. C. W. H. ROHRER, '02, medical assistant.

DR. S. J. FORT, associate professor of Materia Medica, was recently appointed by the Public Athletic League of this city, to instruct a class of four hundred boys in the art of shooting.

DR. A. L. ALBIN, '03, of Charleston, W. Va., is Health Officer of that city, surgeon to the Charleston, West Virginia, Hospital and Secretary of the Tri-County East Pan-Handle Medical Society.

DR. WALTER A. GLINES, '06, is now at the head of the medical staff of the Colon Hospital, Isthmian Canal Zone. Dr. and Mrs. Glines, with their daughter, expect to visit Baltimore next June.

DR. E. A. BOWERMAN, '95, has been appointed surgeon to the fire department of Buffalo, N. Y. The appointment was made after a competitive examination in which Sandy as usual made the best mark.

DR. GEORGE H. P. COLE, '79, is regarded as one of the most expert financiers in Roanoke, Va. He is president of the American Savings Bank, one of the most successful financial institutions of that city.

DR. ALEXIUS MCGLANNAN, '95, has been appointed Chief Surgeon of the First Brigade, Maryland Militia, succeeding the late Dr. I. R. Trimble. Under this new militia law, the holder of this office is the head of the Medical Department of the State Forces.

At the recent convention of the American Association for the Advancement of Science, held in Baltimore, DR. C. HAMPTON JONES, Professor of Public Health, and DR. HARRY FRIEDENWALD, Professor of Diseases of the Eye and Ear, were elected to fellowship in the Association.

The Class of 1904 proposes having a reunion during the commencement week in June. The following members of the class have signified their intention of being present: Horn, McCoy, Halliday, Morris, Nichols, Wertz, McDonald, Fleckenstein, Gillis, Duker, Palmisano, Ellis, Evans, Cohen, Ely, Hartman, Goodwin, Folk, Ed. McGinty, J. McGinty, Seaks, McVay and Boucher.

All who expect to be present will please notify Dr. A. C. Gillis, 1519 N. Caroline St., Baltimore, Md.

Recent visitors to the college and hospital were: DR. A. T. POST, '07, Clarksburg, W. Va.; DR. S. W. PAGE, '02, Anderson, S. C.; DR. E. M. PERRY, '07, North Carolina; DR. C. E. PARK, '05, Avoca, Pa.; DR. JOHN MORRIS, '04, Wheeling, W. Va.; DR. E. F. SMITH, '05, Centerville, Md.; DR. H. M. ORR, '95, La Salle, Ill. DR. J. H. HARTMAN, Jacksonville, Md.; DR. A. N. FALKENSTINE, '85, Glenrock, Pa.; DR. J. F. LUTZ, '94, Glenrock, Pa.; DR. M. KELLY, '02, Charleston, S. C.; DR. O. C. THOMPSON, '06, Cassville, N. J.; DR. A. LAMY, '08, Elizabeth General Hospital, Elizabeth, N. J.; DR. B. O. ROBINSON, '04, Parkersburg, W. Va.; DR. J. G. COLLIER, '00, Sonyea, N. Y.; DR. GEORGE LEMKE, '06, St. Paul, Minn.; DR. M. D. MCCUTCHEON, '08, W. Va.; DR. C. C. TUMBLESON, '05, Mt. Airy, Md.; DR. W. S. BLAISDELL, '92, Punxsutawney, Pa.; DR. D. J. LONG, '97, Piedmont, W. Va.; DR. E. M. PERRY, '07, Spring Hope, N. C.

Correspondence.

GRAFTON, W. VA., February 2, 1909.

Dear Doctor Brack.—Enclosed find check for two dollars (\$2.00) in payment of the JOURNAL for 1908 and 1909.

The JOURNAL is always a welcome visitor. Especially am I interested in the "Personal Notes" and "Correspondence."

I was pleased to see that Viewig and Reich, of the Class of 1902, had at last found time to write to you. I would love to see those two "Irishers."

The P. & S. is well represented in this part of the country and I notice "our boys" are always among the leaders.

It certainly must seem strange about the college without Drs. Latimer, Trimble and Preston, three great men.

Yours truly is doing well; at least, making enough to buy sandwiches. Regards to all.

Yours sincerely,

JOHN H. DOYLE, '02.

DALLASTOWN, PA., January 26, 1909.

CHAS. EMIL BRACK, M. D.

Dear Doctor.—I herewith enclose check for the JOURNAL, an obligation that every alumnus owes to his alma mater. I am one of the boys of 1890, and have been in active practice here for 14 years. I have repeatedly tried to get the address of some of the good old boys of the Class of '90. I have enjoyed a very lucrative practice since I left the college; and, indeed, my work was so laborious that my health failed, and the last two years I have done no country practice, devoting my time to office and town work exclusively, which is very profitable. I have recently been appointed for my fourth term as jail physician for the county of York. I wish I could interest the boys of the Class of '90 for a reunion some time in the near future. Will be glad to correspond with any or all of the boys with that object in view.

Believe me, fraternally yours,

W. H. MINNICH.

PAWTUCKET, R. I., February 17, 1909.

Dear Doctor.—It is with sincere sorrow that I inform you of the death of my beloved husband, Dr. J. Harry Forbes, who died January 27, 1909. The doctor died from an attack of acute jaundice at the Pawtucket City Hospital where he had been one of the surgeons for many years. During his professional experience he was unusually successful. He was medical examiner for a number of different societies and insurance companies in this city. He is survived by two small children.

Very sincerely,

MRS. LOTTIE LOGAN FORBES.

FORT FREMONT, S. C., October 30, 1908.

Dear Doctor.—You will see that I have changed stations again. This is a small post and I requested it as I thought it the best place for my family. I am post surgeon here and find it very satisfactory.

I hope to see you in June. I am a very short distance from Savannah, and if any of you come this way let me know.

I am enclosing a money order for the JOURNAL, which I enjoy very much. With best wishes.

Fraternally,

CHARLES H. HALLIDAY.

KEYSTONE, W. VA., January 27, 1909.

Dear Doctor Brack.—Enclosed please find a check for \$4.00 to pay my subscription to the JOURNAL, which I enjoy very much.

It certainly is sad to think that Drs. Latimer, Trimble and Preston are to be with us on earth no more, but their good teachings and deeds of kindness will extend beyond the grave into the boundless realms of eternity.

And I believe many of us who were students in their day, if we live long enough, will practice their teachings for some time to come.

Kindly remember me to Drs. Dobbins, Bevan, Gardner, McClarey, Cotton, Mitchell, Harrison and Ries. Yes, don't forget Mr. Alberts and Mr. Annen.

Yours fraternally,

H. G. STEELE, '03.

ECKMAN, W. VA., February 2, 1909.

Dear Doctor.—Enclosed you will find my check for two dollars, which amount you will please place to my credit for the JOURNAL. Kindly note change in my address from Keystone, W. Va., to Eckman, W. Va.

Yours truly,
D. G. PRESTON.

PITCAIRN, PA., January 25, 1909.

My Dear Doctor.—As you are still sending the JOURNAL to Dr. J. G. Stewart, I thought it best to inform you that he died April 9, 1905; a grand good man he was. His age was 52 and he died after an operation for gall stones at the Mercy Hospital, Pittsburg, Pa.

Yours truly,
J. R. TILBROOK, M. D.

NEW HAMPDEN, VA., February 10, 1909.

DR. CHAS. EMIL BRACK, 500 E. 20th St., Baltimore, Md.

Dear Sir.—Your JOURNAL of the Alumni Association of the College of P. & S. for January, 1909, came a short time ago.

On the wrapper, I noticed your request, *i. e.*, to let you know of any removals or deaths, so I write you to tell you of my husband's death.

His death was caused from Bright's disease, November 17, 1907.

I would have written to you long ago, but the JOURNAL did not come regularly, so supposed you must have learned of this change.

I think he was a graduate of the Class of '91 and '92, and he spent most of his life in his native county, Highland.

He practiced over two years in McDowell, Va., then removed to the western part of the county, where he spent the remainder of a useful life in active practice until the last month of his stay on earth.

Respectfully yours,
MRS. E. J. JONES.

Monterey, Va., R. F. D. No. 1.

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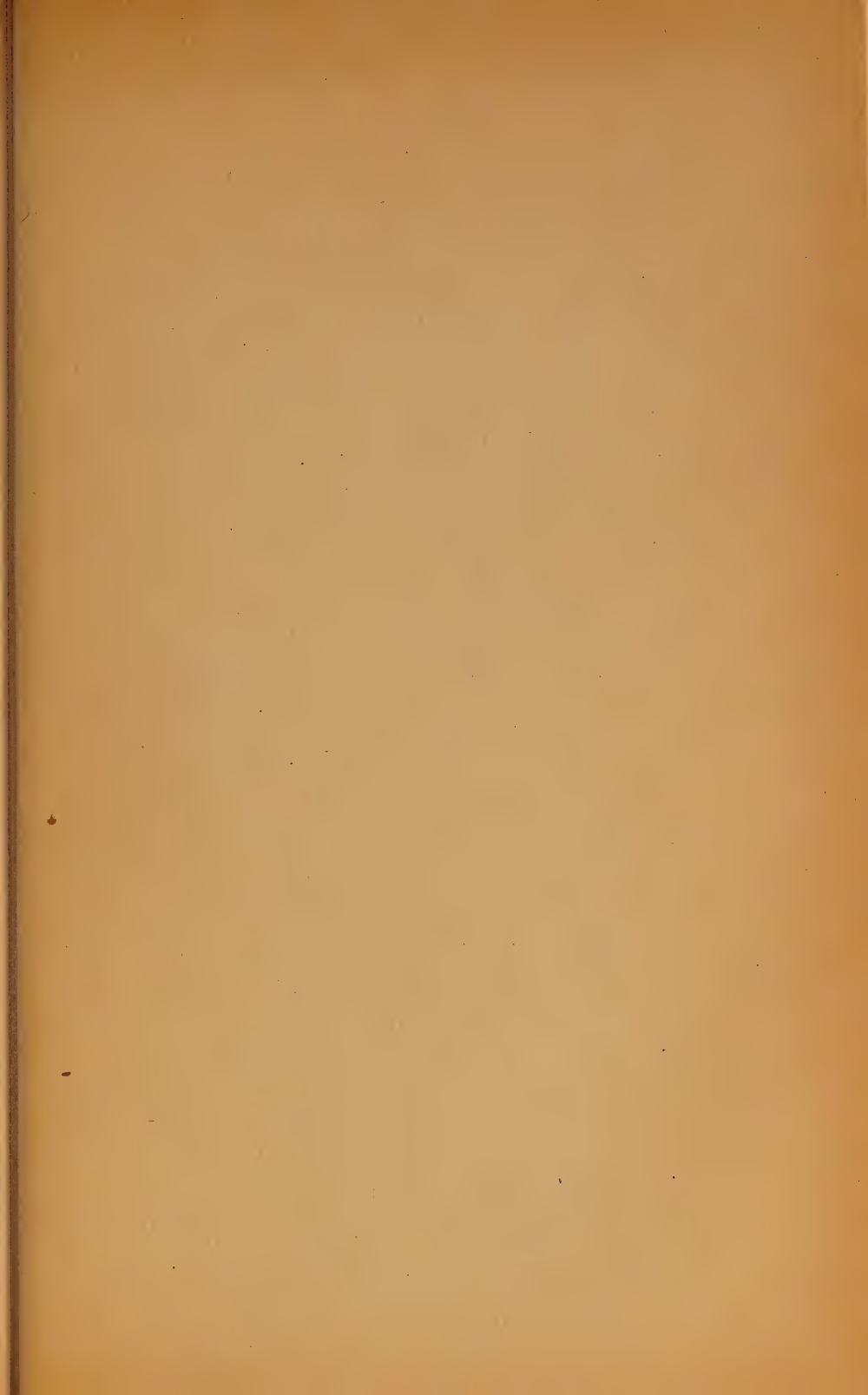
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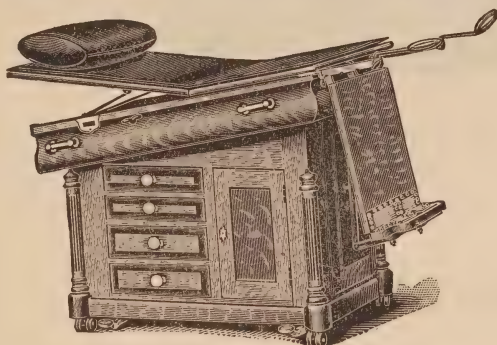
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THE JOURNAL
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BALTIMORE.

THE CONTROL OF THE TROPICS.

By SAMUEL T. DARLING, '03,
Chief of Laboratory, Ancon Hospital, Canal Zone.

THE FORELOPER.

The gull shall whistle in his wake, the blind wave break in fire,
He shall fulfill God's utmost will, unknowing his desire;
And he shall see old planets pass and alien stars arise,
And give the gale his reckless sail in shadow of new skies,
Strong lust of gear shall drive him out and hunger arm his hand
To wring his food from a desert nude, his foothold from the sand.
His neighbors' smoke shall vex his eyes, their voices break his rest;
He shall go forth till South is North, sullen and dispossessed;
He shall desire loneliness, and his desire shall bring
Hard on his heels a thousand wheels, a people and a king.
He shall come back on his own track and by his scarce cool camp,
There shall he meet the roaring street, the derrick, and the stamp;
For he must blaze a nation's ways, with hatchet and with brand,
Till on his last-won wilderness an empire's bulwarks stand.

—Kipling.

There is a narrow zone in the northern hemisphere, bounded in the United States by John Adams and Longfellow on the north, and by Washington, Jefferson and Poe on the south; in Britain, by Land's End and John O'Grout's House. The inhabitants of this zone constitute the "hereditary nobility of mankind." It is they who have gone forth during the past four centuries to

Blaze a nation's ways with hatchet and with brand.

—to conquer a tropical empire and prepare it for their children. The

conquest has hitherto been and is now a political one, the methods being subjugation, colonization and exploitation of the native population. This was begun by the great trading companies, such as the East India Company, and has been continued by various European states.

The cost of this conquest in human lives and fortune has been enormous on account of the ignorance on the part of the invaders of the destroying and debilitating diseases encountered and their inability to cope with them.

The political control of the tropics is a matter of conquest and colonization, of throwing an army of invaders and colonists into the desired territory and filling the gaps made by disease with fresh material from home.

The tropics are desired for their rubber, coffee, ornamental and dye woods, ivory, gold and silver, and for their coaling stations and canal sites, but in the future the tropics will, undoubtedly, be the garden of the world, for every condition there favors continuous and luxurious growth. The temperate zones are becoming crowded with life and their inhabitants will require food from elsewhere. As a consequence of this, the native cereals, legumes, tubers, fruits and vegetables of the tropics will be cultivated, selected and improved by a hundred Burbanks; their valuable characters enhanced, while their insipidity, woodiness and other undesirable qualities will be made to vanish.

Within the tropics is not the place for the continued residence of the "hereditary nobility of mankind." It is not the place for the Anglo-Saxon to spend continuously more than a short generation of years. His children born in the tropics should be educated in cold latitudes and remain in cold weather the remainder of their lives. Race deterioration must be guarded against, which results not only from tropical disease but from the enervating climate with its effect on the tone of tissues—the dilatation and laxness of the peripheral circulation. Race deterioration results also from the effects of the prevailing lowered racial ethical ideals so current in the tropics. Among Anglo-Saxons, particularly in our more Southern States, and it is greatly to their credit that even when they have indulged in miscegenation they kept the racial ethical ideals clean—it is not customary to regard and treat a man as black who has even a trace of negritic blood, but the compelling racial instincts insist upon such obser-

vance. In Spanish America, and even in some of the British West Indies, the barriers of race and color have, in places, broken down, and we find there that a man is oftentimes regarded and treated as white if he have but a trace of Caucasian blood.

If the white man is to exist in the tropics he must learn to protect himself from the debilitating and fatal diseases which have destroyed troops, colonists, administrators and investigators since the time of Columbus, and he must build up, as far as possible, the physical condition of the natives who will bear the white man's burden—do the necessary manual labor.

The history of the conquest of tropical America contains a record of the deaths of enormous numbers of soldiers from disease. Jackson, an English army surgeon, who wrote in 1795, said: "The climate of the West Indies has been fatal to the European constitution ever since its first discovery by Columbus; the fate of the troops who went on the expedition to Cartagena will be long remembered, neither will the loss sustained at the Havannah, Martinique and Guadaloupe soon be forgotten; while the destruction occasioned by the effects of climate at St. Lucia, St. Juan, and even in Jamaica during the late war, is still fresh in our memories."

The fate of our own soldiers in Cuba and the Philippines is familiar to us all. Colonists, everywhere in the tropics, suffer similarly.

The annual losses from plague in India are tremendous and are probably a serious menace to the prestige of England in India.

The tropical diseases frequently strike down valuable men, irrespective of rank or condition. A few weeks after my arrival in Panama, one Sunday the supervising architect died of yellow fever; the following Sunday the deputy auditor died of the same disease, and the following Sunday one of the clerks in the Administration Office. These men were in the prime and vigor of manhood and were almost struck down at work. Very shortly all the ranks of employes were markedly depleted by the terror which spread along the line of work, and although very few men died, yet the effect of these few deaths was sufficient to seriously hamper, for a while, work on the canal. During the French régime, two of the physicians at Ancon Hospital died of yellow fever in one day and four within one week.

Among members of our own profession it should be mentioned that Lazear, Myer and Dutton died on the spot of the very diseases they were investigating. *The Journal of the American Medical Association*, May 1, 1909, reports the death of Capt. Hardy, as well as Lieut. Tulloch, of British Army Medical Corps, of sleeping sickness. Both these men were investigating the disease in Africa.

What are the difficulties, the hitherto insurmountable difficulties, attendant upon the successful colonization of the tropics? They are epitomized in one word—*disease*: malarial disease, including hemoglobinuria, yellow fever, sleeping sickness, dysentery and enteric fever, amoebic dysentery and liver abscess, uncinariasis and plague. These diseases may be placed into groups according to the methods used by sanitarians in arresting their spread and in efforts to control them. One group includes diseases transmitted by suctorial insects. Of these, malarial fever and yellow fever are transmitted by *Anopheles* and *Stegomyia* mosquitoes respectively. The morbidity and mortality from these two diseases, particularly the former, is incalculable. Malarial fever, more than any other disease we are familiar with, has opposed and antagonized the march of civilization. This was pointed out very graphically by Ronald Ross, in an address before the Oxford Medical Society, made sometime ago on malaria in Greece. Major Ross had recently returned from a malarial investigation in Greece and his observations and investigations led him to the opinion that the decadence of Greece was due to the introduction of malarial fever rather than to any inherent racial degeneration. Acute and chronic paludism has interfered in a very great measure with the development of civilization in tropical America. One finds a few cultivated families in the cities or towns, the members of which as youngsters were sent to European capitals for their culture and education, but little or nothing is present to indicate any native artistic spirit or development. Malaria, assisted by uncinariasis, appears to have sapped the energies of most of those who live within a paludic region.

That insidious and fatal fever, called by the Spanish "fiebre amarilla," still lurks in the littoral of tropical America. Since the days of Columbus yellow fever has destroyed thousands and thousands of healthy young soldiers, colonists and non-immune travelers to the West Indies. The Sunday following my arrival in Panama, during yellow fever days, I

visited the English cemetery, which was well filled. Imagine the depressing feeling I experienced when upon almost every other tombstone I read something like this:

In Memory of
 Surgeon R. T. Jones,
 H. M. S. BLENNERHASSET, who died in the City
 of Panama, August 18, 1864, of
 Yellow Fever.
 Erected by his Fellow-Officers.

SLEEPING SICKNESS TRANSMITTED BY A FLY.

Recent important discoveries by Dr. Allan Kinghorn and Mr. Montgomery in Rhodesia and Nyassaland show that other flies than the tsetse fly are hosts and that several varieties of trypanosomes will produce the eucephalitis and characteristic symptoms.

Plague, still destroying hundreds of thousands in India, is spread by the agency of infected rats and fleas. The eradication of this disease in ramshackle cities and towns will be a difficult matter to accomplish without the wholesale destruction of buildings.

Another group comprises dysentery, amœbic dysentery, with abscess of the liver, enteric fever and uncinariasis. These diseases depend for their continuance on the careless and unsanitary disposal of dejecta. It is not alone the contamination of water supplies by fecal matter, but the infection of food by flies, by the blowing about of encysted amœbæ from desiccated feces and by the contamination of paths, trails, yards and the dirt floors of huts with infected fecal matter.

Last year at the end of the dry season I inoculated two flasks of nutrient broth with dust from the road and from the ditch beside the road in front of the laboratory. There had been no rain during four months and the hot tropical sun had baked the earth on the road and in the ditch during that period until it was like powder, yet after four or five days I cultivated amœbæ in each flask and they were exactly like the parasitic but non-pathogenic amœbæ called by Schaudinn "*entamœba coli*," which is found in man and domestic animals unassociated with intestinal lesions.

The disease, uncinariasis, as you know, is disseminated by the infection of barefooted persons walking over moist soil containing embryos of the

uncinaria worms; the soil having been infected by fœcal matter containing uncinaria ova. Moses, one of the earlier great sanitarians, must have had a prophetic mind when he commanded the children of Israel to carry their spears armed on the opposite end with a dibble, which they were to use in digging holes and covering their dejecta. Uncinariasis has decreased in severity considerably in the Canal Zone since the introduction of range closets, the sanitary disposal of fœces and the wearing of shoes by the laborers.

It was said of one of the Roman emperors that he found Rome brick and left it marble, and on account of its relation to uncinariasis it may be said of Americans and natives of the Canal Zone that Americans found them barefoot and left them in patent leathers.

What is the key, the surest key, to the control of these fertile tropical lands? It is the knowledge of the sanitary and hygienic principles deduced from the labor of a few damned doctors, who by the sweat of their brow, working in a fierce torrid heat, sometimes in the very presence of death, discovered the secret methods of the transmission of the fatal and debilitating tropical diseases so disastrous to men of the temperate zone. The application of this knowledge means the destruction of suctorial insects responsible for the transmission of malarial fever, yellow fever, sleeping sickness, filariasis and other mosquito and fly-borne diseases; the protection of non-immunes against infected mosquitoes; the destruction of their breeding places, and the treatment of infected persons in screened hospitals; it means the sanitary construction and control of all range and water closets and the sanitary disposal of fœcal matter and sewage on the large scale; it also means the gradual education of the native population. Part of the sanitary work can be accomplished by draining, ditching, screening, fumigation and the destruction of breeding places, but a large proportion of this work can only be done by education, just as you to-day are teaching our lay brothers here in the states about tuberculosis.

On the one hundredth anniversary of the death of Reed, Carrol, Lazear, Myer and Dutton, the sanitary control of the tropics may have been so thoroughly accomplished that it will never again be said:

Close the door, across the river he has gone,
With an abscess on his liver he has gone;
Many years of rainy seasons
And Malaria's countless treasons
Are among the many reasons why he's gone.

MEDITATIONS OF A COUNTRY DOCTOR.*

BY DR. EDWARD H. EWING, '95.

Mr. President and Members of the Club:

In the good old days when Adam was on this earth and woman had not achieved the important place in society that she occupies to-day, but was merely a side issue, we are taught that there was no such thing as sorrow, pain, sickness and death.

It was really quite a Christian Science sort of an existence that they had in those early days. Unfortunately, however, Adam and Eve climbed over the fence and trespassed in the apple orchard and since that episode this has been a very different world.

To-day to endure sorrow, suffering, pain and death is the common lot of all mankind and it is this darkest side of human existence that is continually before the country doctor. Daily he sees life in all its saddest phases and yet remains invariably an optimist.

Every call brings the doctor to a scene of human suffering and it is his life work to relieve this suffering, and yet after years of attendance upon the sick it must become impressed upon the mind of every thinking physician that the greatest thing in his professional life is not the relief of pain nor yet the cure of disease, but rather what he may accomplish in the actual prevention of this disease and suffering. Splendid and gratifying as it is to see a child recovering from a serious illness through our ministrations, far more satisfying it is if we may do anything to prevent another child or a hundred children contracting the disease.

The emphasis of our lives should not wholly be placed on the effort to cure. Many days and nights are spent in attendance upon those suffering with diseases which perhaps could have been avoided by some reasonable action taken a week, a year or a generation before.

And so to-night it is my purpose to direct your attention in a general way and also in a few particular directions to what I believe the Fortnightly Club and the people of Stoughton should do in a progressive movement toward the betterment of the public health.

But first and for a little time let us look at the situation as it exists to-day among the sick and those that attempt to heal them.

* Read before The Fortnightly Club at Stoughton, December 16, 1908.

We have now, as in all ages, many doctors, healers, physicians, surgeons, allopaths, homeopaths, osteopaths, eclectic and mental healers, faith curists, the physical culturists, clairvoyants, the Dr. Munyon's, the Christian Scientists and one or two others.

When I see the vast number of those who practice the healing art, I am reminded of the passage in St. Mark: "And there was a certain woman that had suffered many things of many physicians and had spent all that she had and was nothing bettered but rather grew worse."

Look at the various methods of healing in vogue to-day. There are the allopaths, a school founded on the belief in the virtue of dissimilars, meaning that the remedy for an ailment is to be had in the use of some agent or drug which produces an effect directly opposite to the effect produced by the disease. There are the good old calomel doctors, who have done and are doing incalculable service to humanity, but who seem oftentimes to believe that if a drop will do good a shovelful will cure. In this, the so-called regular school, was devised the shot-gun prescription with nineteen ingredients; if the patient survived eighteen of the drugs there was a chance that the nineteenth would cure him.

Then we have the homeopaths, a school built upon the belief in the doctrine that "like cures like," that for certain symptoms of disease a drug should be given which if given during health would have produced symptoms similar to those produced by the disease. This seems directly in contradiction to the theory of the allopaths as is also the homeopaths' advocacy of the benefit of minute doses of medicine. To-day all homeopaths are divided into two classes: those that practice homeopathy and those that do not practice homeopathy, and the greater of these is the latter.

Osteopathy is a more modern school that attributes the cause of disease to anatomical and structural errors and believe that the mechanical adjustment of displaced parts is the chief remedy for all diseases.

My personal objection to this school is that their doctrine seems to imply that our various vital organs are not properly anchored to their respective moorings and that the bones of vertebra—they are especially fond of the vertebra—are inclined to wander away and become entangled in the other machinery.

Then the mental healers—known under a variety of names—have a

steadfast confidence in the power of the mind over the body, which is a fine idea if not overworked. We all recognize the influence of the mind as agent for good in the cure of disease, but like many other doctrines it has its very positive limitations, which its most enthusiastic admirers seem unwilling to admit. Strong minds have been known to rule in many homes, not only over an entire household, and have even been known to wander outside their jurisdiction and to trespass upon the physical and domestic affairs of their neighbors. But, personally, I question the power of these strong minds to fling aside with a stout mental effort the evil effects of a dog-bite or the inherited weakness of an indiscreet grandfather. The greatest stumbling block, however, in the path of the mental healer is indicated by the question which I have often asked myself: How are they to require some poor sick chap to undergo a vague process of mental healing and by the power of his own mind raise himself from his sick bed when probably the mind of the sick chap never had any power when he was well? Decidedly, mind cure has its limitations. Roughly speaking, it is curative only in those cases of illness that are caused by harmful mental operations, such as neurasthenia, hysteria and allied conditions induced by anger, worry and overstudy.

With organic lesions such as tuberculosis, cancer and gun-shot wounds, a good mental state is helpful and much to be desired, but it alone is not curative.

The faith curists usually are found marching under the banner of some religious sect. And there is an abundance of biblical authority for their belief. For in James it says: "If there be any sick among you let him call for the elders of the church and let them pray over him—and the prayer of faith shall save the sick." It must be apparent to almost every one that the principles of faith cure cannot be ascribed exclusively to any one or two methods of healing, but that the curative properties of faith are common to every method. Surely every person has some faith in the method which he selects in seeking a cure and so we find the element of faith universal. Some go to the extreme of believing in faith without works, but most of us are satisfied that a splint skillfully adjusted to a broken bone is a good handmaid to faith.

Next we have those who combine the methods of various healers and obtain many enthusiastic disciples, as instanced by the emmanuel move-

ment in Boston. This is a pleasing combination of physical, mental and moral healing or rather a combined attack against disease by nerve specialists and clergymen with considerable nerve. This movement has my blessing, for if the clergy can cure nervous wrecks, the neurotics and the hysterical, will they please get busy and bring relief to a weary world.

This method is in line with Mark Twain's suggestion that "Christian Scientists should have more science and the doctors more Christianity." The emmanuel movement indicates the adoption of the latter part of Mark's advice, but no signs are as yet visible to the naked eye that Mother Eddy's host is becoming more scientific. Theoretically, it seems that the efforts of Dr. Worcester, of the Emmanuel church, embody the most sound methods of healing known to the world to-day. They recognize and act upon the truth that man is a three-fold being endowed with a physical, a mental and a spiritual nature and they believe that disease, defect or error in any one of these states may be corrected best by giving aid to all three. So they combine the efforts of the spiritual adviser with that of the physician and neurologist and obtain good results. I have little patience with such critics of the emmanuel movement as the eminent neurologist, Dr. James Putnam, when he says that the method will work much mischief because it will fall into the hands of the incompetent and untrained.

This is a weak criticism of any policy. If the method itself is right it must not be misjudged or discarded because of a fear that some individual will make improper use of it. That misfortune is common to every good thing in existence. If the principle itself is a true one the practical application of it will be solved in time.

We are all more or less familiar with other healers. Clairvoyants, sleeping doctors, the spiritualists who treat disease, the patent medicine crowd who pin their faith to Dr. Pilton's Specific No. 23, and the Christian Scientists, that most smug, self-satisfied and amiable of all of God's creatures, who have no aches, no pains, no sickness, no death—only dollars and as Mark Twain says, only "love, liver, lights, bones, truth, kidneys, one of a series and without equal."

Can you picture yourself the little child burning with the high fever of pneumonia, its face drawn in agony with every breath, while some strong-minded luminary, a first or second reader, a devout disciple of

Mother Eddy's, sits by the bedside and lays her calm vain-glorious hand on the child's feverish brow and pours forth with sweet and contemptible assurance—to mingle with the delirium of the sufferer—the unintelligent and unintelligible ravings of the “all-in-all and the everything-in-which.” Permit me to say with deliberation in carefully chosen words, that by all the known laws which differentiate the rational human being from the irrational, that, either those Christian Scientists who actually believe so much of Mrs. Mary Glover Baker Eddy's doctrine as can be translated into English, either they or the registered physicians are insane. I will not go farther than to insist that there is no middle ground. One believes in the reality of pain, the other does not. One is right and one is wrong, and since the lives of both are intimately related to their beliefs, one or the other is irrational and insane. Nor am I alone in this opinion. That the Christian Scientists have actually been of service I am ready to admit. That they have developed the element of faith, common to all methods of healing, to an extreme degree is evident. If the old regular school of medicine had not been so wedded to drugs and so neglectful of the psychological side of healing Christian Science would never have existed. The chief reason why there are so many methods of healing is that individuals are inclined to draw unwarranted conclusions from insufficient or ill-defined evidence. One person is cured of a pain in his back, over the kidney, by taking four and one-half bottles of Dr. James' Medical Mystery, with the result that for every backache he thoughtlessly advises the use of the Mystery.

From single isolated cases we formulate general laws. We do not fully realize that before any proposed remedy for disease should have our approval, its use must be carefully observed in hundreds of cases and as no two cases are ever alike, it is apparent, that any definite statement regarding the curative value of the remedy can be reached only after long and unprejudiced study and never from the results of a single spectacular instance.

I do not question the honesty of purpose, the sincerity and the veracity of the individuals who comprise the various schools of medicine and the innumerable groups of healers. These people all have faith in their own methods and any other supposition ascribes to this class of humanity a degree of criminality which is absurd. We will grant then that the vast

majority of all who practice the healing art believe that theirs is the right method and that they are sincere. But more than honesty and sincerity is demanded of those who would heal the sick. Sincerity in regard to a false doctrine only increases the possibility for evil. The asylums for the feeble-minded are crowded with honest and sincere people. Apart from honesty and sincerity there must be a knowledge of the truth.

It is also apparent that cures and most wonderful cures are obtained while the patient is being treated by any one of these many methods. Error creeps in through our giving the treatment credit for the cure. There are but two agents which are common to every known practice of healing. The patient's faith and natural law.

Nature working in perfect order and under definite laws is a great healer, and perhaps 90 per cent of all cases of illness would be corrected by nature herself if not interfered with. Therefore, that school of medicine is nearest the truth which best understands nature's laws and is thereby best able to aid nature in her constant effort to heal.

The laws of nature governing life and physical and mental health are not given us intuitively, but are obtained by experience and education. The child does not understand the simplest laws concerning heat and so burns itself. Fifteen years ago we did not understand the laws of immunity governing diphtheria and so there was no preventative treatment or curative agent as there is to-day. Only by observation, experiment and study are nature's laws revealed. All progress toward improvement in matters relating to public health is dependent upon education.

Every method of healing disease practiced to-day has some good in it, none are near perfection, but some approach more nearly the truth than others. I have much sympathy with every individual that approaches the subject of assisting nature in the cure of disease by a study of nature and a study of man, nature's most highly developed work. With those who practice the healing art, while ignorant of most obvious truths concerning man and the basic principles of natural law and at the same time make no effort to learn what these laws are, I have profound contempt. You would not take your horse to a blacksmith to be shod unless you felt that the blacksmith knew something of the structure of a horse's hoof and yet thousands of people will take their stomachs to so-called healers for treatment when these healers do not know the primary facts concerning the

human stomach, although it is comparatively a simple thing to learn the facts regarding the structure of the human stomach, its location in the body and its function. You may say as some do that a familiarity with the vital organs of the body and their functions are not necessary in treatment by mental healers, by Christian Scientists and others.

I would merely suggest that all who wish to treat disease should be required to familiarize themselves as far as possible with the known fundamental facts and laws relative to health and disease, and that having obtained an educational qualification to treat disease, that they should then be permitted to go ahead with any plan of treatment that they wish to follow. For I have confidence in the educated individual in whatever walk in life he may be found.

Whenever we consider disease, we are compelled to think of health, its opposite, and since any knowledge of disease can be of service only as we understand what health really is, let us consider for a moment what this state which we call health means. In health the body performs all of its functions perfectly and we have the power of counteracting many natural forces.

In a healthy life we are able to raise our bodies from the earth and to some extent overcome the force of gravitation. During a healthy life our bodies remain at a constant temperature no matter whether the surrounding atmosphere is cold or hot. In health we retain a certain amount of moisture in our tissues regardless of whether we are in a dry or a damp atmosphere. During a life of health we have a power to digest and assimilate food for our use and growth. But should disease come, these functions and others are impaired and if death results we find the body falling to the ground unable to react longer against the force of gravitation. In death the body temperature no longer remains at 98.5° Fahrenheit, but speedily becomes that of the surrounding atmosphere; the moisture in our tissues remains or departs in obedience to well-known physical laws and the food that has been taken remains undigested and unassimilated. Now what I wish to call your attention to, is the very obvious fact that life and health are possible only when we conform to natural laws within definite limits.

Our body temperature remains constant in various changes of temperature, but if the temperature about us is raised beyond a certain point

health becomes impossible, the functions of the body are impaired and the body itself may be consumed if the temperature be high enough. We must obey the law of gravitation if we are to retain health. We can move about on this earth, but we are obliged to keep within a few inches of its surface for we greatly endanger life and health if we ascend but a few feet and risk a fall. We can swallow and inhale with safety millions upon millions of germs, minute vegetable and animal organisms, without danger to life or health, but if we should happen to swallow a very few germs of a certain particular kind such as the typhoid bacillus the result may be a serious if not fatal illness. We do not require a physician to tell us that if we fall we will get hurt, if we put our hand in the fire we shall be burned, if we expose ourselves to cold we may be frozen, which suggests the old saw that "Many are cold, but few are frozen."

We do not need a doctor to tell us these things, but there are innumerable other laws in nature that affect health just as surely if not so obviously as those mentioned. This then is the province of the doctor, to know what health is, to recognize disease, to understand the laws which govern health and the consequences that follow their violation. Then he may serve mankind by indicating what laws of nature must be obeyed in order to prevent disease and he may be able to modify the harmful results of laws already broken. In a word, the doctor is to interpret natural law in its relation to health.

This is not as easy as it sounds, for among the laws which govern health are the laws of heredity, the laws of immunity, physical laws of light, heat and sound; questions concerning geographical locations, climate, seasons of the year and astronomical laws; all of these have their place in medicine as factors in health and disease, as do the problems of food, food values and digestion, air and respiration; the more intricate study of the mind and its operations, the soul and its aspirations. For, as already stated, man has a body, a mind and a soul and any system of physical cure, mental healing or religion which does not recognize this is a failure. I wish to stop making these general and sweeping statements and during the remainder of the hour indicate how you and I may be of some real service to humanity here in Stoughton.

Let us begin with one of the simplest things, as a thorough understanding of some glaring fault with its solutions may give us confidence in

solving some of the more difficult problems. Do you know that I see so many children with lice in their hair that I really believe I can tell a louse that comes from the Drake School from a Clapp School louse. I think the Clapp School louse is the fatter. Surely it seems criminal for children to be permitted to carry about so much vermin and filth. Massachusetts has adopted compulsory education, and of this we are justly proud, but has the State a right to say to your child and mine, go and sit daily in school beside this child of filth and disease. Does not the obligation rest upon the State and, therefore, upon you as citizens to rid the schools of this most common of all contagious diseases, and the principle involved here is the same if applied to the more serious contagious diseases such as consumption, diphtheria and various skin diseases. That this unhealthful condition exists is distinctly your affair and mine and the business of the State, but the fact is that its solution is left to individuals, the parents of the afflicted children, to do about as they please. When the public realizes that a case of lice, smallpox or consumption in school or out of school is an affair of public interest and concern which demands public action, then will we have just begun to accomplish something worth while. The remedy in a case of contagious disease is to exclude from school every infected child, and a vermin-infected head is a contagious disease. What is done with the child after it has left school is a matter for parents, health boards, truant officers and societies. In so far as the schools are concerned simply send them out. If you send out all the infected children and are also careful not to admit those that are diseased, the problem is solved immediately in so far as the public school is concerned. Why has this not been done? There has been no one to do it. Teachers do the best they can, but it is the work for which they have had no training and at least while the matter has been left to them the result has been a failure. Then, again, some teachers are a bit sensitive about minute investigation leading to the detection of undesirable parasitic inhabitants.

The Commonwealth of Massachusetts has provided by statute for thorough physical examination of all public school pupils by the most competent authorities available. This subject has been presented to the voters of Stoughton twice and the voters have answered that they would spend \$800.00 on the sick trees of Stoughton and \$5.00 on the contagiously dis-

eased public school children. Prominent educators are becoming convinced that the basis of all education must be physiological rather than psychological. That in the home, the public school and the church greater emphasis must be placed on the proper development of the body and proper care of the body before genuine advancement can be made in the right development of the intellect and the soul. The most just criticism of our public school system to-day concerns the wrong attempt that is being made to give all children, regardless of their physical and mental condition, the same quantity and quality of instruction. Consideration must be given to the fact that many children are undeveloped and backward and because of a false pride these pupils should not be driven to competition with normal children, to the disadvantage of both and the heart-breaking disappointment, oftentimes, of the slow pupil. All children need instruction in correct habits of the body as well as the mind. They need to be taught the vital importance of fresh air and also how to breathe it. But after years of effort to make public school recess a time for breathing fresh outdoor air, we find to-day many of the teachers sending the pupils out of doors at recess, while the teacher remains to breathe the foul, second-hand air which has just been used by fifty children. What kind of physical or even intellectual instruction can be expected from such a teacher, and the teacher that thinks she is not physically strong enough to breathe God's free, pure, outdoor air is not qualified to teach in any school.

Here in Stoughton the common attitude of mind in relation to matters of public health is one of magnificent indifference. No concerted action has ever been taken to exterminate the festive louse which can be seen so readily with the naked eye and of course no real progress has been made in killing out the microscopic germs and parasites that cause consumption, measles, scarlet fever and other dangerous diseases. It is simply appalling how indifferent people can be. They care very little about the fact that some child on Clapp street has diphtheria or that a girl on Lincoln street has consumption and yet these same people become wonderfully excited if either of these diseases attack members of their own households. Then they are interested in our local board of health—mostly, however, in a critical way. They wonder why the board of health permits this or that nuisance to exist? Why this cesspool is allowed to overflow? Why

more strict quarantine over this family is not observed? Why the State Board does not do something about sewerage? And they forget that during their whole earthly existence they have been voting for road supervisors, representatives to the great and general court and fence viewers, but never within the memory of the oldest inhabitant has ever a vote been cast for a board of health and yet the statutes provide for the election of such a board—but they are never elected, no not even nominated. The man who drew that law was wise; he knew that the public was not interested in the matter of health, so it was provided that in any town where they were too lazy to elect a board of health the select men should be required to serve as such a board.

Let me do justice and say that our select men do well, considering that they have this undesirable job thrust upon them and also in consideration of the fact that they have the actual fund of 13 cents per day, the amount appropriated in town meeting assembled by the voters of Stoughton with which to further the interests of public health. They bury a dead dog or two, not so much because of a fear of any undesirable putrefactive processes, but more from a sense of grief that it has ceased to be a source of revenue to Wales French's library. In the federal government we have a department of labor, of law and departments of the navy and of war, planning night and day how men's lives may be destroyed, but there is no department of public health devoted to the saving of life. You may write the department of agriculture how best to stop the ravages of the squash bug which is eating the garden vines and you will receive a helpful answer, which will be a condensed summary and the last word on all matters pertaining to the subject. But what department of the United States government is devoted to stopping the tuberculosis bug from eating our children? President Roosevelt said last Wednesday in his message to Congress, "There are numerous diseases which are now known to be preventable, which are, nevertheless, not prevented. This nation cannot afford to lag behind in the world-wide battle now being waged by all civilized people with the microscopic foes of mankind, nor ought we longer to ignore the reproach that this government takes more pains to protect the lives of hogs and cattle than of human lives."

The first step to be taken is that for the concentration of the proper bureaus into one of the existing departments. The President might have

gone further and declared, as some of us believe, that there is surely work enough to be done in the prevention of disease and the relief of human suffering to engage the services of a well-equipped and efficient National Department of Health that is not a mere part of an existing department. But I suppose that as long as localities are not interested in local boards of health, we will not likely have a National Department of Health. So that instead of making every possible effort to render human lives stronger, healthier and more full of happiness, we shall go on maintaining a great navy and a splendid agricultural department and spend the nation's money in armor plate misplaced too far below the water-line and on books entitled "How to tell the age of a horse by its teeth."

No discussion of a physician of Stoughton on matters of health can be complete without reference to consumption, the great scourge in Stoughton. Diphtheria and smallpox and other contagious diseases occasion some alarm when they appear in our own homes or perhaps next door to us; but toward tuberculosis we manifest no concern lest we contract the disease, and yet consumption in the past five years in Stoughton has slain just eight times as many as have died from all the other contagious diseases combined. The exact figures show that in the past five years 80 persons have died of tuberculosis, while in the same period but eight persons have died from all the other contagious diseases combined, including smallpox, scarlet fever, diphtheria, measles, typhoid, whooping-cough, etc. What have you ever done about this? Do you imagine that the tuberculosis germ intends to leave Stoughton some day of its own accord? I wonder sometimes how many must be killed by it before Stoughton decides to drive it out. It will cost more than 13 cents a day to get rid of it. A campaign to destroy tuberculosis, which is possible, will cost as much as it now costs to bury those that die in their almost single-handed conflict against this disease. In many respects the problem is simple. We all breathe air; if tuberculosis germs are in the air we are exposed to the disease and may become one of its many victims. The solution of the difficulty is to keep the germs out of the air. This brings us back to the care of those sick with the disease who are the source of the germs. The care of these patients; proper regulations and oversight to see that they observe cleanly habits and make proper use of disinfectants and fumigation, the expense of which is to be borne by the community.

Proper nursing and every care, even if the public pay the cost, will be cheap in its public benefit. The disease is communicated through the drying and blowing about of the sputum of the invalids and so in the factory, the school and the home, the disease spreads. An organized effort to stamp it out is surely worth while.

The question of clean milk is important, whether we admit it or not. There are just two kinds of milk, good and bad, which suggests the story of the little girl from the city who was spending her first day in the country watching the cows being milked, and getting her first drink of fresh cows' milk, she said to her mother, "I wish our milkman kept a cow." The laws of nature seem to have been devised with the intent that babes should drink mothers' milk and calves should drink cows' milk, but nowadays when it is time to feed a baby the fond mother takes a can-opener and cuts open a can of condensed milk, prys the sugar off the lower half of the can, mixes it with muddy pond water and the baby begins life as a gambler, taking a chance with death. Sometimes the baby wins, sometimes the condensed milk wins.

Mothers point with pride to certain youngsters raised on this food—indeed they should be proud. It is quite a feat to have accomplished. Imagine a two-year-old child walking out to the back yard and gazing thoughtfully on a pile of empty cans and muttering, "Behold my mother." Even fresh cows' milk is not the ideal food for infants. I trust no one will rise and dispute with me the fact that nature designed cows' milk for the nourishment of calves in order to develop cowhide, hair and hoofs. To see a farmer raising a calf in the barn wholly on cows' milk and his wife trying to raise the baby in the cradle on exactly the same food always has raised in me a fear lest the babe should develop horns and in some cases in after life they have. But discussing the relative merits of diet for babies recalls a public school story. Willie flung his hand at his teacher and complained that George Henry Phipps who sat next to him was telling him stories. That George knew a baby onc'ted was fed on elephant's milk and gained 10 pounds a day. The teacher very properly reproved George for telling Willie such rubbish and asked him what baby that was and George answered, "The elephant's baby."

Whenever a baby is raised on any other food than mother's milk that baby is on the wrong food. Cows' milk modified by the addition of Mel-

lin's, Eskay's or similar preparations is the nearest substitute. Cows' milk is a staple article of diet for adults as well as children and the necessity for its purity is urgent. My suggestion is that you take a walk some pleasant morning and inspect for yourselves the conditions under which the milk you buy is produced. Personally, I have a profound respect for the character of that milkman who away out in the country where he is not under observation conscientiously observes correct methods of cleanliness. Clean milk is not an easy article to produce and I do not believe that it can be furnished for less than 10 cents a quart. Some of our milkmen are giving us good value for the 8 cents they charge. You have all heard the milkmen in the early morning hours humming that good old hymn, "Shall we gather at the river." For that and other reasons I have always been glad to know that our milk came from Dry Pond. But I hope you will go and see conditions as they exist in the different barns and milk rooms. You will be delighted or disgusted according to where you go. As I said a moment ago, if there is a man on earth that should receive credit for good work it is the cleanly milkman.

Milk is not the only food that should be kept clean. Meats require great care in handling, but they are not so dangerous to health, if unclean, as milk, for the simple reason that they are usually cooked—which process destroys all germs—while milk is taken uncooked or raw. People should demand clean foods, foods exposed unnecessarily to the dust of the street and other filth should be refused, nor is it desirable, as some one has said, that the fly should be permitted to wipe its feet on the steak before we eat it.

Stoughton has a fair water supply. I believe our town water is quite free from disease-producing factors. No typhoid and no dysentery except among comparative strangers and those that drink well water in the thickly settled districts. The exceptions to this general statement are very rare. If we see typhoid fever, our first thought is, where has this patient been during the past few weeks—surely not in Stoughton. If we meet a case of real dysentery we know that the patient has been drinking out of one of Stoughton's grand old wells. The public have not yet learned that a water that looks good, smells good, tastes good and is cool and sparkling may yet be a dangerous water to drink. The first requisite for every drinking water is that it be free from disease germs, this I

think is true of our Stoughton town water. I only wish that it might look better and taste better, yet I am not complaining about that. It is one of life's little mysteries why people will construct cesspools within a few feet of an old well which is 15 feet lower than the cesspool and then expect that all leakage from the cesspool will run uphill away from the well. Old wells are dangerous. The fact that your grandfather drank from the well and that his family were quite free from illness proves nothing. In those days they did not know anything about the strange practice of pumping 217,000 gallons of water into the town every day without making any provisions for the care of the waste water after it had been used by several thousand people. This suggests the subject of sewerage which I will not touch upon, but direct your careful attention to the report that is to be made by the committee appointed to consider that subject. The probability is, however, that if this committee does not suggest a remedy that it will not be long before the State will advise us in the matter and will insist on their advice being followed. The subject is an important one in its relation to public health and I have confidence that the committee will serve us well in their investigations.

The Fortnightly Club should interest themselves in the question of public health—not necessarily as the Fortnightly Club—but as individuals who are willing to do a definite work for the sake of positive results. A local health organization should be formed here in Stoughton which should be broad enough to include representatives of every religious society, every club, every lodge and every family, with the definite purpose of furthering the adoption of all needful health regulations and in particular of maintaining a district nurse in Stoughton. This question of a district nurse has been solved years ago. We do not have to undergo the risk of experimenting with a new thing. It was satisfactorily worked out by towns more progressive in matters relating to health. Canton has adopted the method with splendid success. As I understand it, the first problem in the care of the sick to-day is attention to their physical wants, such as a real cleansing bath, a bed that is clean and well made, a proper regulation of the temperature in the room and proper food and drink given at proper times and a little medicine, or little faith or bit of mind cure on the side. These aids to health may be obtained more quickly and most advantageously by one who is trained to supply them. And this the trained nurse is able to do as no one else can do.

The nurse who is trained for the special work of district nursing can adapt herself to all manner of homes and all kinds of patients. She will bring great relief to many tired and worried women; she will comfort where there is pain; she will cure disease and she will save lives that otherwise would die. But her greatest work will be educational. Her methods will teach in a way that will not be forgotten, cleanliness, healthfulness, happiness; she will teach as she works, the virtues of fresh air and of sunlight, of proper food and how to care, not only for the sick, but for the well. A trained nurse can prevent much sickness.

Now the financial problem involved is this. In a factory town conditions are such that the men and most adult members of the home must leave the house at certain hours and leave the sick to the haphazard care of neighbors or oftentimes mere children. If the husband spends \$10.00 a week for an untrained nurse, he may find in Stoughton many good women who will go and work for him, but the husband will be paying a large fee for unskilled service. On the other hand, if he sends to the city for a trained nurse the expense will be at least \$25.00 for the week and then there are many homes in Stoughton where a regular trained nurse will not stay, any more than you would go and stay there night and day.

The district nurse is the remedy; she has her room and regular boarding place and she divides her working time among as many cases of illness as is possible. Some places she may stay a week, other places 15 minutes. She is a free agent to do as she thinks best under the directions of the association, because her salary is guaranteed. Of course no competent nurse can live in Stoughton and serve all classes unless she is relieved of financial responsibility. On the other hand, the nurse's work is not charity; no one is pauperized by her ministrations. Every one who can pay is expected to pay and those who cannot pay must have her aid just the same. The result is that a man in moderate circumstances can obtain the best possible service by employing the district nurse, for but a portion of the day; during this time the nurse can personally care for the most urgent needs of the patient and give detailed instruction concerning other matters. And this service will be rendered for compensation that is adjusted to the circumstances of the family, the usual charge being 25 cents an hour or less.

We, as individuals, can rarely ever go in person and wait upon the sick. But we can join in an association and send a competent, skillful nurse to act for us. It will cost about \$800.00 a year to maintain such a nurse; and the nurse should earn about \$300.00, leaving a sum of \$500.00 to be provided by the public. Five hundred dollars can be spent in no other way with such satisfying results. It is not my purpose to enter a lengthy discussion of this subject, but only to indicate what is essential and to bring the matter before the Club for discussion. There are a number here who have already given it their interest and attention and an opportunity I hope will be given them to express their opinions.

It is my belief that at the present time the establishment of a District Nurse's Association in Stoughton is most urgent and that it is the most practical thing we can do if we have a spirit of love and charity still within us. Some one has said that "Safety and sanity lie in our ability to think individually and to act collectively." This I trust we may do concerning all questions of public health.

But now after this discussion of miscellaneous medical topics in which I have mentioned the various schools of medicine, you are no doubt wondering to which school I owe allegiance. As to the kind of a physician I am, I will answer with a quotation from holy writ, "And Nathan being sick, trusted not in the Lord but called a physician, and Nathan was gathered unto his fathers."

THE ALUMNI ASSOCIATION MEETING.

The Annual Alumni Meeting, June 1, will be remembered very pleasantly by those who were so fortunate as to be present.

The meeting was called to order promptly at 8 p. m. by President Howard, and the minutes of last year's meeting read by the secretary, according to rule.

President Howard then delivered a very interesting address, embodying much hope and wise suggestion for study along lines of serum therapy and physiological chemistry. He thought the time would come when at least a majority of infectious diseases would be treated by antitoxins.

The second address of the evening was by Dr. Darling, Superintendent of Government Laboratories in the Panama Canal Zone. His subject, "The Sanitary Conquest of the Tropics," was interesting from many

viewpoints. He told of the many lives sacrificed in the crusade made against the diseases of this region, and how malaria, yellow fever and typhoid have been almost entirely eliminated. He also gave much information about the climate and the intermingling of the races in the Zone.

Dr. C. C. Hersman, of Pittsburg, was the next speaker on the program. He suggested much that would encourage persistent effort, *based upon the advances of recent years*, for success in any field of medicine.

Dr. G. A. Davis, of West Virginia, praised the P. and S. and recalled conditions there in 1880.

Dr. R. E. Lee Hall, who deserted medicine for law and politics, but who has always been a staunch friend of his alma mater and the medical profession, spoke of medical legislation.

Dr. Chas. F. Bevan represented the faculty in emphasizing the earnest endeavors of the School to give out to students the best medical education possible and upholding the standard of medical education.

Dr. Chambers, as usual, quietly roasted everybody in sight, but especially the treasurer.

Dr. J. W. Kidd, '84, when called upon, expressed his pleasure in being at the meeting and again renewing acquaintance with classmates, whom he had not seen for 25 years.

From side remarks, we would conclude that Dr. Kidd was a little kid when he graduated, but he has developed big in many respects since then, even into a good kiddier.

Dr. Geo. A. Strauss, '83, most happily told of many humorous occurrences in the early eighties. His anecdotes were most thoroughly enjoyed, but are too good to print.

The meeting adjourned to attend a smoker and light lunch, which had been provided for the occasion.

The following officers were elected for the ensuing year: President, Samuel Darling, M. D.; First Vice-President, H. G. Simpers, M. D.; Second Vice-President, T. W. Causey, M. D.; Third Vice-President, W. A. Griffith, M. D.; Secretary, Walter L. Nickolls, M. D.; Treasurer, Chas. E. Brack, M. D.; Assistant Secretary, J. W. Chambers, M. D. Executive Committee, A. G. Gillis, M. D., H. Fleckenstein, M. D., Walter D. Wise, M. D. Publication Committee, Wm. S. Gardner, M. D., Editor; John Ruhräh, M. D., Associate Editor; Chas. E. Brack, M. D., Business Manager and Treasurer.

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE YEAR BOOK.

The Year Book for 1909 is such an unqualified success that it gives us great pleasure to call the attention of the Alumni to the fact that the committee to take charge of the publication for 1910 has already been announced and are getting actively to work.

The Editorial Board consists of: J. E. Marschner, Editor-in-Chief; A. N. Ball, J. B. Kilbourn, N. B. Whitcomb, B. H. Swint and C. W. Zurchner; and the Business Board of: J. Thorkelson, Business Manager; E. S. Hamilton and F. L. Jennings.

This publication is a very good example of the progressiveness of our students and for the past three years has been one of the interesting features of the student life, and one from which the Alumni could derive great pleasure and benefit. It is a very attractive magazine-size book bound in flexible leather and contains about 170 pages of reading matter, with cuts of the faculty, students and various views of the college building, of the hospitals and laboratories. The book shows the kind of material that is being used in the making of the physician of to-morrow, and also gives a good idea of the men who are training them.

We understand that the next issue will contain, in addition to the usual material, a complete history of the college from its earliest days, with short biographical sketches and photographs of the more noted of our Alumni and also views of the new additions now being made to the Mercy Hospital.

The clinic is an excellent advertising medium and one which every Alumnus should have on his office or waiting-room table, and we are sure that he would be proud to have his patients see from what school he was graduated, and that he himself would derive great pleasure from keeping in close touch with the doings of the students and can in a measure best renew the pleasures of his student days.

Every Alumnus should subscribe to this Year Book, the price of which is \$2.00, subscriptions for which must be made in advance, as only the number subscribed for is printed. It should be the pleasure and duty of every one of us to secure a copy of this interesting publication. All subscriptions, inquiries and contributions should be sent to the Editor-in-Chief, Mr. J. E. Marschner, 1115 Park Ave., Baltimore.

MEDITATIONS OF A COUNTRY DOCTOR.

We have had for some months in the file of the JOURNAL a most entertaining article by our old friend, Buck Ewing, who after having served as gynecologist in the City Hospital, as cartoonist to the house staff and artist in general to the visiting staff, gave up the thoughts of a career in the city and settled down in Stoughton, Mass., where he has become one of the pillars of the community. We reprint from the *Stoughton Sentinel* the meditations of Dr. Ewing, which were read before the Fortnightly Club last December. We commend this article to all our readers and are sure that all will find a pleasant and profitable hour in reading it.

CLASS RE-UNIONS.

Frequently our Alumni request us to arrange for a re-union of a certain class. We are at all times most willing and anxious to do anything that will advance the fraternal spirit and bring our Alumni together.

It is extremely difficult, however, to have a successful class meeting unless some one member of the class, who has ample time, will take the matter in hand and approach each member of his class by a personal letter.

The only successful class re-union was that of '79 and the success of that was due to the untiring efforts of one member, who was busy for a year in getting the men together.

In 1908 we mailed to every member of '84 and '04 a letter requesting them to take part in a class re-union in 1909. There was no enthusiastic response, but quite a number promised to attend the meeting. Incident-

ally Dr. Britton D. Evans canvassed the class of '85 and received favorable responses from 34 men. Shortly before the meeting Dr. Evans called the re-union off and postponed it until 1910. Several left home prior to receiving this notice and were much chagrined to find that there was no meeting. One Alumnus had travelled from Texas for the purpose of meeting his classmates.

Of the classes of '84 and '04, so few actually put in an appearance that it made the management feel very uncomfortable when asked by those who did respond, "Where is the class of '84?" or "Where is the class of '04?"

I would suggest that some member of the class which desires to meet will take the matter in hand personally, elect a committee, one or two members of which may reside in Baltimore or nearby; and almost every class has a representative either in Baltimore or vicinity. A subscription of \$5.00 should be forwarded as an evidence of good faith. This amount would cover the amount of the banquet ticket and provide for some entertainment in addition.

The JOURNAL and the officers of the Alumni Association will gladly assist in any movement of the kind and help to make it a success.

We would like to hear from the members of '95. If a sufficient number show a willingness to have a class re-union in 1910 we will take the matter up.

CHARLES E. BRACK, '95.

THE ALUMNI RE-UNION AT ATLANTIC CITY.

During the meeting of the American Medical Association, at Atlantic City, one of the most successful re-unions in the history of the institution was held. The success is to be attributed in a large measure to the efforts of Drs. William J. McCaw and Pearl Williams, of Providence, R. I., who took the initial step towards making the necessary arrangements.

Headquarters were established at the Hotel Poinsettia, where the re-union and smoker were held on June 9. The association owes a debt of gratitude to the proprietor for the many courtesies by him during these meetings.

Dr. C. Hampson Jones served as chairman at the re-union and smoker. He elicited many expressions of intense loyalty and devotion to our alma mater from men who graduated as far back as the seventies to the present, and who hailed from the far off Pacific to the Atlantic, and the Gulf to the Canadian line.

About eighty, including guests, attended this meeting. Everybody had a thoroughly good time, and there seemed to be a unanimous sentiment in favor of an annual re-union.

The following Alumni registered: William J. McCaw, '81, Providence, R. I.; Standish McCleary, '90, Baltimore, Md.; P. Williams, '96, Providence, R. I.; Benj. F. Coe, '95, Dixonville, Pa.; S. W. Woodyard, '95, Greeneville, Tenn.; H. G. Beck, '96, Baltimore, Md.; Wm. R. Howard, '79, Rochester, N. Y.; J. M. Johnston, '96, Huntingdon, Pa.; Julius Friedenwald, '90, Baltimore, Md.; John J. O'Malley, '08, Baltimore, Md.; M. A. Bailey, '93, Hartford, Conn.; J. J. Jones, '79, Wilmington, Del.; G. W. Mitchell, '—, Baltimore, Md.; Frank Dyer Sanger, '88, Baltimore, Md.; Wm. S. Gardner, '85, Baltimore, Md.; John Ruhrah, '94, Baltimore, Md.; Emil Novak, '—, Baltimore, Md.; W. E. Delaney, '91, Slate Run, Pa.; R. S. Martin, '81, Stuart, Va.; Thomas J. McLarney, '97, Waterbury, Conn.; M. J. Morrissey, '97, Unionville, Conn.; T. J. Cummins, '03, Plattsburg, N. Y.; Chas. F. Blake, '93, Baltimore, Md.; R. M. Rau, '93, Wheeling, W. Va.; S. J. Waterworth, '93, Clearfield, Pa.; S. T. Darling, '03, Canal Zone; M. D. Morris, '92, Eldersburg, Md.; Wm. A. McMillan, '03, Charleston, W. Va.; F. J. Snyder, '87, York, Pa.; Franklin Bree, '85, Williamsport, Pa.; Alfred T. Gundry, '94, Catonsville, Md.; Lewis H. Gundry, '90, Relay, Md.; Chas. J. Sawyer, '95, Windsor, N. C.; W. M. Nihiser, '82, Hagerstown, Md.; H. W. Strader, '85, Sacramento, Cal.; G. C. Thieme, '96, Baltimore, Md.; A. H. Hawkins, '95, Cumberland, Md.; Fred Van Tobel, '92, N. H.; J. C. Cobey, '96, Frostburg, Md.; J. W. Lacy, '96, Lisbon, Md.; A. C. Harrison, '—, Baltimore, Md.; W. B. Robertson, '08, Baltimore, Md.; F. H. Suiss, '80, Taneytown, Md.; W. H. Memnich, '90, Dallastown, Pa.; Harvey P. Jack, '91, Canister, N. Y.; J. B. McElroy, '93, Memphis, Tenn.; Chas. S. Rebeck, '96, Harrisburg, Pa.; A. W. Colcord, '93, Clariton, Pa.; J. H. White, '83, New Orleans, La.; C. C. Hersman, '84, Pittsburg, Pa.; C. T. Horn, '78, Lehigh, Pa.; G. Milton Linthicum, '93, Baltimore, Md.; W. J. Hunt, '91, Glens Falls, N. Y.; Ed. L. Broadrup, '91, Cumberland, Md.; J. M. Scanland, '97, Montana; H. W. Hodgson, '71, Cumberland, Md.; C. Hampson Jones, '90, Baltimore, Md.; L. F. AuRum, '86; C. Garrabrant, '86, Atlantic City, N. J.; H. S. Jarrett, '84, Towson, Md.; J. Williams Lord, '—, Baltimore, Md.; Otto Schaefer, '—, Baltimore, Md.

THE ANNUAL BANQUET.

The Annual Banquet was held at the Hotel Belvedere, Wednesday, June 2, at 10 p. m., after the commencement exercises.

Dr. R. E. Lee Hall presided as toastmaster and in his bright and humorous manner introduced the speakers. Dr. Hall's efforts added greatly to the success of our annual banquet.

Dr. Chambers responded for the faculty, which he started to roast, but changed his mind and told of an agreement he had made to donate \$5.00 to the College Library for every baby born to a member of the adjunct faculty whose name began with a B. He thought he was safe, but since then he has been called upon three times. First for Dr. Thomas Brown, then for Brack and lately for Beck, and the end is not yet.

Dr. Wm. R. Stokes read a poem entitled, "Theology and Mythology," which with his permission will be published.

Dr. DeWitt Faucett, '09, in an excellent address, responded for the class of 1909.

Dr. Wm. Veenstra, '09, in a most clever manner made the prophecy for the members of his class. It would interesting in 1919 to compare the prophecy with the actual destiny of the members of 1909.

Dr. Chas. F. Bevan, our Dean, made a strong plea to the Alumni for their support and encouragement. We must root for our alma mater upon all and every occasion and we have the right to do so. As an unendowed school the P. and S. depends absolutely upon its reputation and the reputation of its graduates. The present cost of running an up-to-date medical school is such that the financial return is but sufficient to give the course as it should be given.

It is only by maintaining the high standard and by giving the best possible course that the unendowed school can compete with those supported by ample endowment.

Dr. W. S. Blaisdell gave the boys some excellent advice and encouragement. Do not let a failure discourage, but rather let the failure be a stimulant to make the better fight and win out.

Dr. Harry Friedenwald reported the excellent standing of the P. and S. boys in State board examinations.

Dr. W. R. Howard, '79, feels so much at home in Baltimore that he

promises to come down from Rochester every year to attend the College exercise.

Among those present were: Drs. W. E. Magruder; R. E. Lee Ellis, '04; Geo. A. Strauss, Jr., '08; J. H. Steenberg, '08; J. W. France; W. T. Riley, '90; W. S. Blaisdell, '90; Harry Friedenwald, '86; Harvey G. Beck, '96; Sam. T. Darling, '03; Edgar Friedenwald, '03; H. A. Herring; A. G. Barrett, '00; G. W. Mitchell; Otto Schaefer; H. S. Jarrett, '84; Chas. F. Blake, '93; A. W. McGlannan, '95; A. F. Riess, '03; Chas. E. Brack, '95; H. H. Esker, '06; Emil Novak; Walter A. Wise, '08; H. H. Haynes, '08; D. C. Mock, '04; A. C. Gillis, '04; Launcelot Ely, '04; Harvey Fleckenstein, '04; O. H. Duker, '04; W. D. Thearle, '08; Alfred Ullman, '02; A. G. Rytina; U. Bordesski, '07; T. Fred Leitz, '07; Julius Friedenwald, '90; Samuel Schmidt, '01; Jno. J. Stiefel, '01; G. M. Litsinger, '98; G. Thieme, '96; Jno. G. Onnen, '08; Geo. A. Strauss, '83; Chas. F. Bevan, Dean; Rogers; W. R. Stokes; Geo. W. Dobbin; Douglass; A. C. Harrison; G. W. Simpson, '73; W. F. Hines, '77; J. W. Chambers, '78; W. R. Howard, '79; B. F. Noland, '81; Jno. S. Robinson, '84; John Ruhrah, '94; Thos. H. Brayshaw, '85; Wm. P. Spratling, '86.

COMMENCEMENT EXERCISES MERCY HOSPITAL, 1909.

The eighth annual commencement of the Mercy Hospital Training School for Nurses was held as usual in the College Amphitheater of the College of Physicians and Surgeons, May 25, 1909, at 8 o'clock.

The transformation of this familiar circle into a garden bower, formed a fitting background for the happy faces which soon enlivened the scene.

The exercises were opened with prayer by Rev. T. B. Hughes, Chaplain, followed by an address by Rev. John S. Keating, S. J., who endeavored to impress great loyalty as the motto for nurses, together with an endeavor for self-knowledge, self-reverence, self-control.

The Dean, Dr. C. F. Bevan, then awarded the diplomas to the eight young ladies who had completed their three years' course: Maryland, Miss Margaret Cecilia Kennedy, Miss Elizabeth Evangeline Neville, Miss Mary Anna Raab, Miss Goldie Estelle Watson; Pennsylvania, Miss Birdie Golden Mills; West Virginia, Miss Bertha Etheldrea McNamee; Michigan, Miss Neva Iris Learn.

The gold medal for efficiency in theoretical and practical nursing was awarded to Miss Goldie Estelle Watson.

Dr. Wm. P. Spratling then addressed the young ladies, speaking in high terms of the respect which is due a nurse when she faithfully performs her duties to humanity; the lesson he advised was the influence of tact.

The Dean made many happy remarks to the class endeavoring to make them appreciate fully their training under such favorable auspices and intimating the change of name by which the School shall afterwards be known, Mercy Hospital Training School for Nurses.

Personal Notes.

DR. H. K. OWENS, of Elkins, W. Va., is secretary of the Barbour-Randolph-Tucker County Medical Society.

DR. R. L. MARTIN, of Stuart, Va., has been elected secretary of the State Board of Medical Examiners of Virginia.

The following alumni have recently been visitors at the College: DR. ROMAN WISE, '08, Glen Rock, Pa.; DR. A. T. POST, '07, W. Va.; DR. W. A. GLINES, '06, Panama; DR. J. G. FLYNN, '01, Ridgeway, Pa.; DR. J. C. PECK, '07, Mouldsville, Va.; DR. J. W. JOHNSTON, '85, Clarksburg, W. Va.; DR. R. M. RAU, '93, Wheeling, W. Va.; DR. WM. A. McMILLAN, '03, Charleston, W. Va.; DR. H. W. STRADER, '85, Sacramento, Cal.; DR. J. A. POWELL, '07, Harrellsville, N. C.; DR. PEARL WILLIAMS, '96, Providence, R. I.

Marriages.

DR. ANDREW COLIN GILLIS, '04, 1519 N. Caroline St., was married May 4, 1909, to MISS BERTHA FISCHER, of Baltimore.

DR. WALTER K. BLANKENSHIP, '10, of Chillicothe, Ohio, was married last February in Ellicott City Md., to MISS WINIFRED BRENNEMAN, of Lancaster, Pa. The marriage was kept a secret until after the close of the college year when it was announced. Mrs. Blankenship is a graduate of the Woman's College, Baltimore.

Obituary.

DR. JOHN W. BERRY, '84, a member of the West Virginia State Medical Association, died at his home in Flatwood, April 21, from poisoning by carbolic acid taken in mistake for aromatic spirits of ammonia, aged 45.

DR. CHARLES L. BUDDENBOHN, Washington University School of Medicine, Baltimore, '73, coroner of the southwestern district of Baltimore county in 1898, died at his home in South Baltimore, April 7, from angina pectoris, aged 58.

DR. HENRY BASCON BURKETT, '78, of Hillsboro, Ala., died in Birmingham, Ala., April 23.

DR. CHRISTIAN M. SCHULTE, Washington University, Baltimore, '76, at one time ward physician in the health department of Baltimore, died at his home in this city, May 5, from pneumonia, aged 58.

DR. HORACE A. PAXTON, '78, Buffalo Forge, Va., a Confederate veteran, died at the home of his nephew in Lexington, Va., June 12, aged 66.

DR. JOSHUA SWIGERT, Washington University, Baltimore, '63, formerly of Brazil, Ind., died in the Cook County Institution, Dunning, Ill., May 3, from exhaustion, due to chronic morphinism, aged 71.

DR. RICHARD C. HAMMOND, '78, died at his home in Burleigh, Ellicott City, June 13, from cerebral hemorrhage, aged 55.

DR. WILLIAM R. BIRD, '80, a member of the Medical Society of the State of Pennsylvania, died at his home in Chester, May 13, from pneumonia, aged 51. At a special meeting of the Delaware County Medical Society, a committee was appointed to prepare and present suitable resolutions regarding the death of Dr. Bird.

CLASS OF 1890.

Next year will be the twentieth anniversary of the class of '90. The annual meeting of the Alumni Association would afford an excellent opportunity for a class re-union. Members interested kindly communicate with Dr. W. T. Pratt, Rockville, Md.

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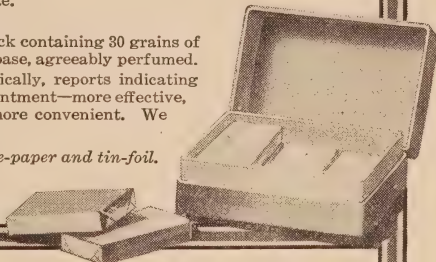
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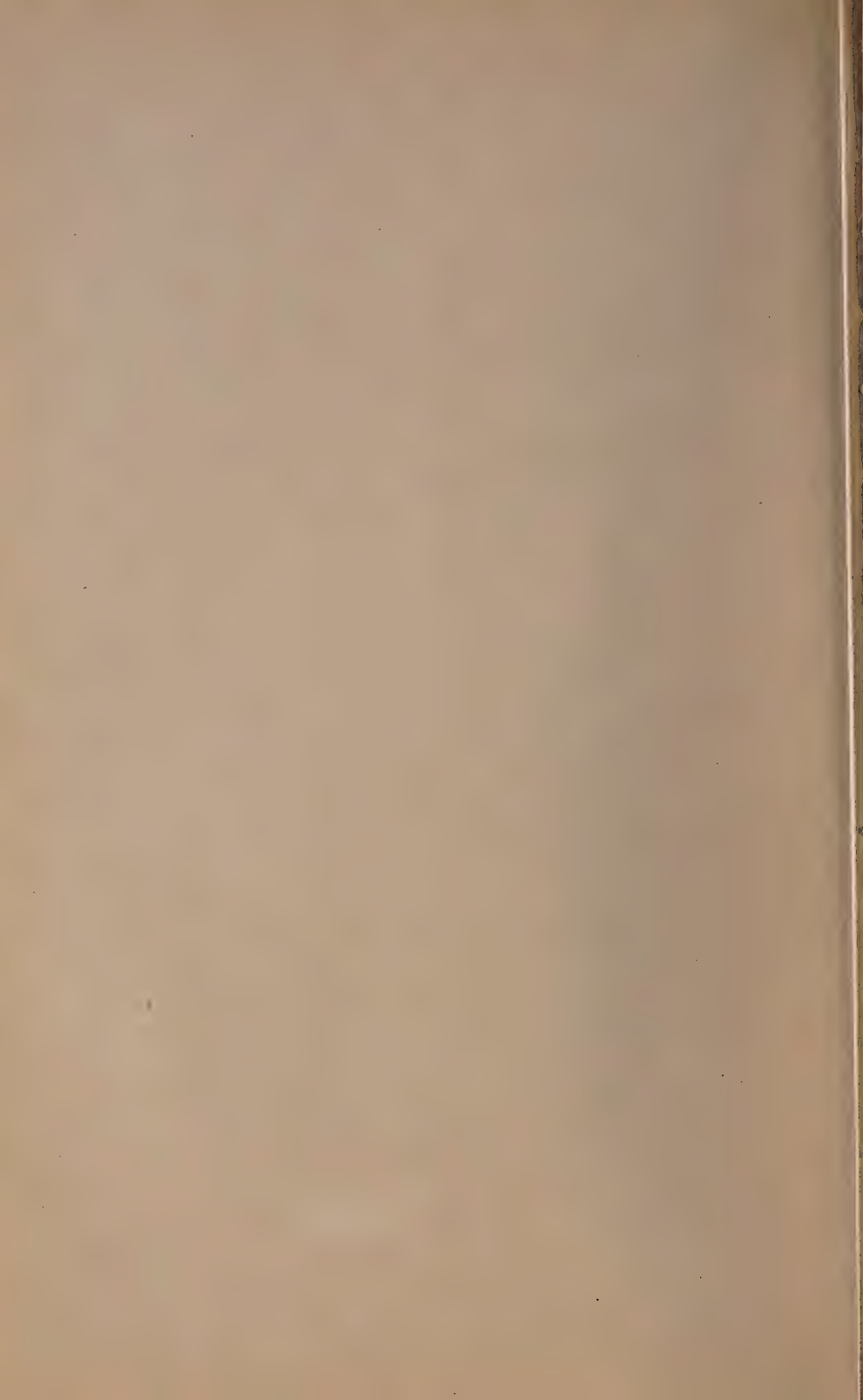
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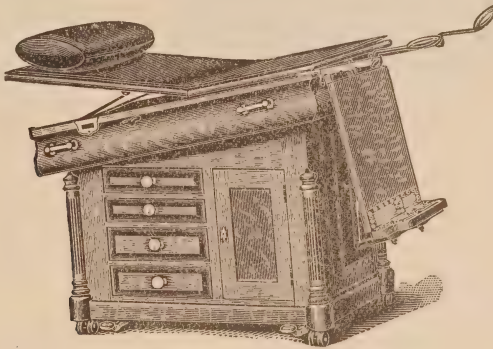
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LACERATION OF THE BRAIN AND SUB-DURAL HEMORRHAGE—REPORT OF A CASE SUCCESSFULLY TREATED BY MEANS OF BI-LATERAL INTERMUSCULO-TEMPORAL DECOMPRESSION.

BY DR. ALEXIUS McGLANNAN, '95.

Our knowledge of the effects of increased intra-cranial pressure is largely the result of study of tumors of the brain and its appendages. Physiologists, neurologists and surgeons have all contributed information. Recently the surgeon neurologists, notably Cushing, have applied this knowledge to the treatment of traumatic lesions of the skull and its contents. A number of valuable articles have been published. Although the work is still in its beginning, enough experimental and clinical evidence has been recorded to justify operation for the relief of pathological tension of the cranial contents and to allow us to recognize the condition in most cases.

Increased intra-cranial tension from injury is the result of hemorrhage and is always an acute compression. The effect of this compression is chiefly on the blood vessels with venous stasis as an early result, and later arterial compression with an increase of pressure. The increase in tension may be local or general. The distinction between local and general increase is important, because it is possible to have a great degree of local pressure without serious general symptoms, while even a less severe general pressure will be fatal because of implication of the vital centers of the medulla in the general anemia.

The danger of increased intra-cranial tension is compression anemia of the vital centers of the medulla, but nature has provided physiological methods for their protection. The falx cerebri, tentorium, and other membranes so separate the different parts of the brain, that it is possible to have a high degree of local pressure at a distance from the medulla without serious vital disturbance. The membranes protect the vital region, and the free circulatory anastomoses quickly balance the blood supply. On the other hand, when there is general increased tension the protection must be vascular alone. Here we see a most elaborate system of pressure balance developed by the circulation of the cerebro-spinal fluid, and local and general variations in blood pressure progressively coming forth to protect the medulla. Of course an injury involving the medulla may at once destroy the vital centers, or an injury may be so severe that all the powers of compensation are unable to balance the pressure, and coma and death quickly follow.

Kocher (Nothnagel's *Specielle Path. und Therapie*, 1901), has divided the effects of increased tension into four stages, representing progressive increase of tension. Clinically it is common to have the symptoms bridge these stages. Occasionally the process is arrested at one or the other stage, or it may pass directly on to the last almost immediately, depending on the severity of the lesion. The stages of general increased tension, as described by Kocher, are:

First. The stage of compensation in which the escape of cerebro-spinal fluid and the narrowing of the veins makes the disturbance slight and without severe symptoms.

Second. Failing compensation. Here the pressure is sufficient to lessen the amount of blood flowing through a considerable part of the capillary field, but without serious alteration in the nutrition of the vital centers.

Third. General circulatory involvement. Here the tension is sufficient to involve the medulla and call forth the general vasomotor regulation for compensatory action.

Fourth. Failing general compensation.

The symptoms of compression vary with the stages and progress in a like manner. Serious cases pass rapidly on to the late stages. At first the symptoms may be mild and insignificant. Headache is practically

always present, and with it there may be some mental dulness. Later, in progressive cases, or early in the more serious injuries, in addition to pronounced headache we note vertigo, restlessness, excitement or delirium. Now certain objective symptoms become apparent. Of these the rise in blood pressure and the state of the eye grounds are most important. The ophthalmoscope reveals dilation of the veins which are also tortuous, and often a beginning edema of the nerve. The external veins of the head, especially the venules of the eye lids, are dilated and the face is usually cyanosed.

In the third stage there is a marked rise in blood pressure; the respiration approaches the Cheyne-Stokes type; the pulse is slowed to 40-50 per minute and is bounding in character, of the vagal quality. Examination of the retina shows choked disk. As the fourth stage is approached there is gradual failure of the compensatory action of the general circulation, the blood pressure falls, the pulse becomes rapid, the heart's action and the respiratory movements become irregular and the patient passes into coma and dies from respiratory paralysis.

The treatment is at once apparent. If the progressive increase of intra-cranial pressure leads to this final wearing out of compensation, or if the tension has already worn it out, the proper procedure is to relieve the pressure. This is best done by the intermusculo-temporal decompression operation (H. Cushing, *Surg. Gyn. and Obst.*, March, 1908).

The advantages of this particular method are many. It uncovers the middle meningeal artery and the tips of the temporal lobes, the structures most often damaged in head injuries. The resulting bone defect is covered by strong muscle which controls the tendency to hernia of the brain. The operation can be performed rapidly and with safety.

Technique of operation. (*Surg. Gyn. and Obst.*, March, 1908; *Annals of Surgery*, May, 1908.) The patient's head is carefully prepared by shaving and scrubbing. It is not necessary to shave the entire scalp, a point of importance when operating on women. The shaved area can be so mapped out that after recovery the remaining hair may be arranged to hide the defect. The scrubbing must be very thorough and the scalp further cleaned by ether, alcohol and bichloride. The incision is made in either of two ways—a crescentic incision about an inch above the ear,

the points of the incision coming about an inch in front of an inch behind the tip of the ear. The scalp is reflected down uncovering the temporal fascia. Or a straight incision may be made over the temporal region down to the fascia. With either method of exposure the fascia is divided perpendicularly, the muscle fibers separated bluntly and retracted. The skull is exposed at the bottom of the wound and a button of bone removed by the trephine. If the bony opening requires enlargement, this is done by flat rongeur forceps. With sub-dural lesions the dura bulges into the wound and is opened after it has been picked up with forceps and transfixed by fine silk retraction sutures. In opening the dura care must be taken to avoid wounding the pia. After the dura is open, the clot, if any is found, is gently removed by salt sponging, etc., and any bleeding point is ligated. In closing the wound the dura is not sutured, the muscle and fascia are brought together with fine catgut and the scalp sutured with interrupted fine silk. In traumatic cases with sub-dural hemorrhage it is necessary to drain, because of the oozing which we cannot stop. A small piece of protective is brought out from the brain through the lower angle of the wound. This drain and the silk sutures are removed at the end of forty-eight hours. Whenever the unilateral decompression does not relieve the pressure symptoms a similar opening should be made on the other side.

The following is the report of my case of laceration of the brain and sub-dural hemorrhage cured after the decompression operation :

Surg. 1050. Laceration of brain, sub-dural hematoma, cerebral compression. Bi-lateral intermusculo-temporal decompression. Recovery.

The patient, a white man, age 26, was admitted to the City Hospital May 31, suffering from an injury to the skull. He had fallen from a tower, about eighteen feet, striking on his head. He was unconscious and had a scalp wound. When admitted he came under the care of Dr. A. C. Harrison, to whom I am indebted for the opportunity of treating the patient and reporting this case. On June 4 Dr. Harrison was called out of town and left the patient in my charge. At that time the patient had rallied somewhat. Consciousness had not been fully restored, although he seemed to understand commands. He was quite restless and rather incoherent in his speech. The pulse and respiration had been for the most part about 80 and 24, occasionally dropping to 68 and 18, respectively. On June 4 there was no cyanosis, the circulation and respiration were undisturbed, and the condition seemed to be that of the second stage of compression, with local compensation. There was a gradual change in the condition until the eighth day, when there were fairly distinct evidences of increasing tension. The pupils were evenly dilated and reacted normally. The pulse became slower and the respirations a little stertorous,

with cyanosis of the face and some superficial venous engorgement. On this account I had Dr. Herring, the neurologist of the hospital, see the patient and give his opinion concerning operation. Dr. Herring noted among other conditions, double choked disk more marked on the right side. Considering this in connection with evident failure of local compensation, and the absence of any focal symptoms, we decided that a sub-temporal decompression should be done on the right side.

Operation June 8, 1908. Intermusculo-temporal decompression of the right side.

Under ether anesthesia I opened the skull through the split temporal muscle. There was no extra dural lesion and the dura bulged through the bone opening under considerable tension. When the dura was incised about 5 cc. of straw-colored fluid spurted out. The tip of the temporal lobe was badly lacerated and softened, but no distinct clot was found. A searcher passed down under the temporal lobe allowed the evacuation of a considerable quantity of blood-stained fluid. A protective drain was brought out from the brain through the lower angle of the wound and the wound closed in the usual manner.

There was no shock and the patient recovered from the anesthetic without any trouble. There was immediate relief of the general circulatory disturbance, but the patient remained unconscious and the eye grounds on both sides continued to show choked disk. At the first dressing on the fourth day after operation, the stitches and the drain were removed. The wound had healed per primam except at the drainage opening. There was distinct bulging of the temporal area and a slight flow of bloody fluid followed the removal of the drain. The wound went on to final healing without complications.

There was no further change in the condition of the patient, the choked disk and the unconsciousness persisted. The bulging of the decompressed area was constant. About the tenth day after the operation occasional evidences of failing general compensation began to occur. There would be periods of cyanosis, with stertor and slow bounding pulse, associated with periods of fluctuation in blood pressure and approach to the Cheyne-Stokes type of respiration. A second decompression on the other side was strongly advised, but the patient's friends objected to further operation. On June 24, after consultation with Dr. Charles Macgill, the family physician, consent was obtained and I decompressed on the left side.

Operation June 24, 1908. Intermusculo-temporal decompression of left side.

The skull was opened as in the first operation and the dura incised. A lenticular clot was found under the dura, extending forward over the temporal lobe. The bone opening was enlarged to allow the complete removal of the clot by wet salt sponges. No bleeding point was found and the wound was closed with a drain in the usual way. The patient showed considerable mental improvement soon after the operation. The stitches and drain were removed on the fourth day after the operation and the wound healed without complications. The eye grounds cleared up. Then followed a period of no change that lasted for several weeks. The patient was more or less unconscious, would obey orders, but took no interest in his surroundings. This period was followed by one of gradual improvement, ending in recovery.

On October 1 the patient reported at the hospital and was examined by Dr. Schmitz, the resident surgeon, who reported him completely recovered.

BIER'S METHOD.*

BY DR. A. ULLMAN, '02.

That the experimental period of Bier's Hyperemia has passed into the stage of practicability, is evidenced by a most casual examination of the medical literature of the past twelve months. That the soundness of the somewhat revolutionary principles enunciated by the German surgeon has been verified in a great measure can no longer be doubted. The treatment of inflammations by the constriction band, suction cups and dry heat has taken its place among the approved methods, and although some of the successful results reported, might well be attributed to the optimism of the enthusiast, the fact can no longer be disputed that in the hands of reliable observers, the new treatment has met with a degree of success that would seem to warrant a belief in yet greater possibilities. Bier does not claim entire originality for the whole of this novel method. What he does maintain is that up to the date of his first announcement there had been no scientific development of the principles involved, and that it remained for him to bring the subject up to a basis of practicability. Be that as it may, his teaching certainly must tend toward revolutionizing our ideas on the treatment of inflammation. In pursuance with Bier's theories, we must no longer combat it, but on the contrary, artificially increase three of its cardinal manifestations, viz.: heat, redness and swelling. Bier, himself, tells us that every functioning organ is hyperemic during its activity, and that in every form of growth and regeneration, local hyperemia is present. If we accept the reactions of the body as useful efforts of nature, we must admit that hyperemia is the most widespread of all auto-curative agents. Wily Meyer outlines the aim of the treatment as an effort "To increase the beneficent inflammatory hyperemia resulting from a fight of the living body against invasion." In a word, we must add an artificial hyperemia, and thus increase the quantity of blood in the particular diseased portion of the body. One of the principal reasons for a thorough trial of this new method of treating inflammation would appear to be its simplicity and the lack of objection from the patient's standpoint. The procedure and technique are easy, and a fair trial of its advantages may be obtained with little effort.

* Read at the first annual meeting Pennsylvania R. R. Surgeons' Association, November 2, 1908, Broad Street Station, Philadelphia, Pa.

Its broad field of usefulness has already been sufficiently demonstrated. Its efficacy in the relief of pain alone must stamp it of great value. The treatment has been successfully adopted as a prophylactic in the warding off of severe infections, as well as a means of reducing mild inflammations. It encourages repair in the face of infection, and by its aid, a small incision may answer, where without it, a more extensive operation would be required, thereby substituting a small scar for a much larger one. The packing of cavities, the cause of so much pain to the patient, may frequently be avoided by its adoption; while the number and size of operations may be diminished by those simple procedures which have placed in our hands a remedy that is at once safe and sane, as well as frequently beneficial in its results.

To summarize the range of usefulness of Bier's hyperemic treatment, it is only necessary to state that it has been successfully used as an analgesic, as a bactericidal agent, as an absorptive, as a solvent and as a nutrient. The diseases for which it is recommended are daily increasing in number. Most enthusiastic reports have been published as to its efficacy in metritis, mastitis, superficial glandular lesions, burns, gonorrhoeal rheumatism, neuralgias, tubercular arthritis, as well as in other joint inflammations, traumatisms, furuncles, carbuncles; and, the literature of the year includes one case of inoperable sarcoma.

Three methods of the application of hyperemia are recommended, viz.: by the use of the elastic bandage, by the suction apparatus, and by means of hot air. Each has its distinct indication, and each can be applied with comparative simplicity, although the apparatus required for the hot-air treatment is somewhat elaborate, requiring for its proper use a more or less extensive outfit. Obstructive hyperemia by the constricting band is the simplest of the three methods, and only requires an elastic bandage for its application. The apparatus required, where suction is indicated, is somewhat more extensive.

The elastic band is tied above the affected part just sufficiently tight to cause a feeling of heat and tingling but not of any pain. There must not be a stasis of the blood. The circulation should not be impeded. The pulse should not be obliterated below the bandage. The bandage should relieve, not cause pain; the limb should swell and retain its warmth. Its surface should become red, but by no means blue or white in color.

In inflammation of the arm and leg, the location of constriction must be the upper arm and thigh. The time of application ranges from one hour to twenty-two out of the twenty-four.

Suction hyperemia is recommended for mastitis, metritis, furuncles, carbuncles, infected wounds. Suction cups adapted to conform to the various parts of the body are now to be had. A cup of the correct shape and size to fit the part to be treated should be selected, and in applying same, the edges should be well greased. The application should be made with gentleness, as the process should not prove painful. Where the presence of pus is inferred, a small incision should first be made to permit of its exit as the suction is brought to bear upon it. The skin at first is red, then bluish red, blue, and finally, very dark blue. The pressure should never be so great that the skin becomes blue.

The induction of hyperemia by hot air requires a specially constructed box, through which the limb is passed, and which is supplied with the necessary heat by a flame lamp or stove, or so connected as to transmit its heat to the inside of the box. Care should be taken to avoid extremes in heat and especially any pain. For the treatment of trigeminal neuralgia and sciatica, a hot air douche is to be used, a tube conducting the dry hot air from the stove or lamp; and thus permitting the affected part to be sprayed with a continuous flow of heat.

Blech of Chicago, in his translation of Bier's original work, quotes an instance in his own practice, which so ideally illustrates what may be accomplished, that it is well worth repeating. A recently married woman, for five weeks had been suffering excruciating pain from acute inflammation of the right elbow joint. Every known medicinal treatment having been resorted to by her two attending physicians without permanent good, they advised an operation. Blech was called in and a diagnosis of gonorrhoeal arthritis was made, the husband admitting previous infection, and the gonococci having been found in the uterus. The suffering of the patient was extreme and the mental agony of the husband was most marked. Passive hyperemia was resorted to and the improvement was so marked that all idea of an operation was at once abandoned. Thus a simple piece of rubber tubing prevented a somewhat dangerous and mutilating surgical operation. In the literature of the past twelve months we see the range the new treatment has already taken.

Jayle and Loewy of Paris, report seven cases of metritis treated by a special cupping glass, devised to fit over the cervix, in which all were relieved of pain and otherwise improved. Heinsins of Berlin, mentions fifteen cases treated similarly with like results. Baetzner treated at Bier's clinic, forty cases of gonorrhœal arthritis by passive hyperemia, with favorable results in all instances. Ritter of Berlin, reports that in the treatment of local burns, he has brought about marked relief in pain and promoted healing by the application of constriction hyperemia.

In the treatment of mastitis, Jaschke found that the suction glass was of the greatest value, and that fifteen minute applications of the glass markedly increased the secretion of milk where for any reason it had been suppressed. Gregory of Leipsic, applied the constricting band as a last resort in three cases of crushing injuries of the foot or leg which absolutely refused to heal after weeks and months of varied treatment. The effect was apparent almost at once, and the wounds cleaned up and soon healed. M. G. Seelig has used the method in over one hundred and fifty cases during the past two years at the Jewish Hospital Dispensary, St. Louis, and it has never failed him. When properly applied, he has shortened the duration of treatment from 50 to 75 per cent, relieving the patients of the pain and discomfort attendant on large granulating wounds and packed sinuses. Harvier, in a communication to the French Medical Congress, reports having obtained excellent results in eight cases of gonorrhœal rheumatism. Mary Hess Brown, of New York, visited Bier's Clinic and was very favorably impressed with the treatment and cures. While there, she saw infected scalp wounds, lacerated wounds of the forearm, gonorrhœal wrist joint, acute mastitis, large carbuncles, tubercular knee and elbow, treated with good results. Stein of Munich, was highly gratified with the method, and never observed any bad after effects. Ogata of Leipsic, has made extensive application of the vacuum glasses in cases of mastitis, boils, carbuncles, abscess and felons, with favorable results. He also treated twenty-five cases of fissure of the anus, seventeen cases of hemorrhoids with relief of pain.

Dr. D. N. Eisendrath, of Chicago, at the Michael Reese and Cook County Hospitals has treated hundreds of cases with cups and constricting band. He declares that in acute and acute pyemic arthritis or gonorrhœal arthritis no better treatment than Bier's hyperemia can be ap-

plied. Dr. John B. Murphy, of Chicago, states there is nothing of which he knows that has come into surgery in the last ten years as a practical application, which appears to him to have as much value, and he is sorry to say practiced so little and so frequently misused, as Bier's hyperemia.

Conclusions.—In concluding this paper, it might well be stated that Bier's hyperemic treatment is a pain reliever when properly applied in selected cases.

It reduces inflammation and aborts it.

It hastens the cure.

It preserves tissue and function.

RELATION OF THE ACCIDENT INSURANCE EXAMINER TO THE ATTENDING PHYSICIAN.

BY DR. W. EDWARD MAGRUDER.

Since the birth and extensive growth of accident, health and liability insurance many conditions have arisen which involve the conduct of physicians who examine for companies on the one hand, and those who attend the policy holders on the other. Situations are encountered, and have to be met, which are not provided for in our existing code of ethics.

Accident and health insurance are written for the mutual benefit of the company and the assured and upon conditions and at premium rates founded upon statistics and experiences of the company and acceptable to the policy holder.

Any unusual departure from these conditions, due to misrepresentation or fraudulent claims, causes loss to the insuring party beyond the expectations provided for in the premium collected and as a result the insurance becomes unprofitable and the resources of the company to that extent impaired.

Not only do companies have to be vigilant in the detection of possible fraud, but they are confronted by a far greater danger in the lack of knowledge on the part of policy holders and attending physicians of the conditions and limitations under which the insurance was written and voluntarily accepted.

This form of insurance is written without preliminary medical examination and reliance is placed upon the truth of the statements made

by the policy holder in his application, and this application becomes, in lieu of such medical examination, a part of the contract of insurance issued thereon.

It is easy to see how important it is for the policy holder to thoroughly understand and properly appreciate the necessity of dealing fairly and stating frankly his age, previous accidents and illnesses, other insurance carried and the amount of his income, with any additional information required from him by the company, before a proper estimate can be made of the risk and the appropriate form of insurance issued.

An individual buying protection against certain accidents or illnesses with a stipulated amount of indemnity for those conditions and at a premium rate estimated upon the basis of the risk assumed, is insured against those losses for which he pays and not for those upon which no protection is guaranteed.

A limited health policy or a limited accident policy is sold for a premium commensurate with the liability carried and cannot, under any circumstances, be expected to pay indemnity for diseases or accidents not covered by such premium nor for periods of time in excess of those provided for in the special contract under consideration.

Failure to realize these facts on the part of the policy holders and attending physicians has been the cause of much criticism of insuring companies and, consequently, their examining physicians.

The conscientious attending physician is not without his troubles. He is often confronted by a claim blank at the bedside of his patient who, either through an exaggerated idea of the seriousness of his own disability or possibly from a desire to secure indemnity not covered by, or in excess of, that provided for in his policy, expects the assistance of his doctor in establishing his claim. The physician knows full well that his answers to the questions will be scrutinized by his patient and that the degree of satisfaction they give will often determine his future attendance upon the interested claimant. The compensation of the attending physician may be directly involved in the situation and it is certainly hard for his judgment to remain uninfluenced and for him to give the company all of the information which may be desired. It is hardly possible to expect it of him considering that he is both human and, no doubt, ignorant of policy conditions and, too, he may have acquired the

incorrect opinion that companies are prone to take advantage of technicalities and avoid the payment of just claims. He may not realize that, in some limited forms of health policies, by stating the leading symptom or complication instead of the original disease he may be assisting the claimant in securing money from the company for a longer period than that for which his premium paid and thus, inadvertently, becoming party to a fraud.

The fact that an insurance company *is an insurance company* is no reason why advantage should be taken of it. Unfortunately, particularly under industrial policies, extremely close settlements have, in some instances, been made by agency managers who, working under profit-sharing contracts and thus being pecuniarily interested, have thought only of the necessity of controlling the loss ratio.

These isolated instances of possible unfairness have done much toward creating prejudice on the part of some physicians and of the insuring public against insurance companies. This is certainly in marked contrast to the opinion one forms after coming into close contact with heads of the claim departments of the various reputable accident insurance companies throughout the country. They are all willing and anxious to pay all just claims and pay them promptly.

Owing to these conditions and for many other reasons it becomes necessary for accident insurance companies to secure the services of examining physicians who will investigate and report to them the exact condition of claimants and advise them concerning the desirability of continuing the risk after the existing disability has terminated.

The established custom under the code of ethics, as practiced by our fathers, made it unprofessional for one physician to visit a patient of another and make any examination except at the request, and in the presence of, the attending physician. Conditions have arisen which, of necessity, have modified this practice.

The companies in order to properly estimate their liability and to secure the information desired, have provisions in their policies which give them the right to examine policy holders as often as they may think necessary, and, upon this basis, the insurance is written and accepted. The physician who is called to attend such a policy holder for an illness or accident, and assuming the case, acquires not only a patient but an

insured patient with a contract, the conditions of which must be carried out in order to make it operative.

Accident examiners are paid for examinations at prices which could not be accepted by them were it not for the fact that they can do their work without conflicting and in connection with their other duties. If they are engaged in other practice they can see claimants on their daily rounds and often without going materially out of their way. If they happen to be largely engaged in insurance examining, in order to make it pay, their examinations must also be made with some regard to the economy of their time and the urgency of the case in hand.

In the case of life insurance examiners it is different. They are obliged to respond to appointments arranged for them by the agents and have little choice but to drop everything else and answer the calls, and for this they receive a larger compensation than accident insurance examiners, but not commensurate with their more exacting work.

If, in compliance with the old custom, an accident examiner was compelled to meet the attending physicians in all cases his work for the companies would prove unprofitable at present fees, and could not be undertaken by any properly trained medical man. The delays incident to meeting the attending physicians would end in his making so few examinations each day that he would not be able to continue the work. Then, on the other hand, the company or its local representative may not know who the attending physician is, having simply received notice of the illness or accident, and the examiner in order to ascertain this fact would be compelled to make a preliminary visit to the assured and another later with his doctor and for this extra service he would not be paid. The premium collected does not justify the payment of fees by the company for any unnecessary visits and examinations.

The accident examiner proves valuable to companies in many ways, and, if prompt in his examinations and thorough in his observations may be able to materially assist them in protecting their interests.

In accident examinations his investigation may determine the seriousness of the injury and enable him, in urgent cases, to report by telephone or telegraph to the home office of the insuring company information which might be the means of starting a search for evidence which perhaps could not be secured later. In this way the company may be saved a

possible claim for accidental death when the case is clearly a suicide by securing the facts while they are available or an autopsy at a time when it is of some value in establishing the true cause of death.

Careful investigation of the conditions under which an accident occurs may prove useful in establishing whether or not the claimant is entitled to double indemnity under his policy and this is but another of the many functions of the well trained accident examiner.

The instances are too innumerable to mention here in which examiners have been able to protect their companies against unnecessary claims by their early and painstaking investigations, and their proper appreciation of serious conditions and possible serious results.

In the case of examinations under health policies the importance of early and careful examination cannot be ignored. The exact nature of the disease and its consequences in all the relations it may bear to the claim under consideration and the future of the risk must be known by the company before an intelligent disposition of the claim can be made.

Aside from the inconvenience of meeting attending physicians for the purpose of examining their patients there are other considerations. The trained examiner has, from long experience, acquired facility in securing from the claimant and his surroundings information which his company needs, and this he can best secure alone, for the presence of the attending physician cannot fail to cause some restraint and interfere unconsciously with the easy relations which would otherwise have been promoted between the claimant and the examining physician. Irrelevant matters are likely to be discussed and the examiner finds, after leaving the case, that his examination proved incomplete.

Except in those rare instances where, for some reason, the parties interested make a special request that the examining physician meet the attending physician for the purpose of examination, and where fixed surgical dressings have to be removed, it is far better for the examiner to interview the claimant alone.

Tact, above all else, is required of an accident examiner and he must at all times, avoid any discussion with the claimant which might discredit the judgment and ability of his family physician. In no other situation is the golden rule so important to follow nor so easy to infringe.

A high sense of honor, a wide acquaintance with the other physicians

in his territory, good medical training and ability to inspire confidence are all essential to the making of a competent accident examiner.

As the truth is what he seeks and all he desires in his work it is not hard, if he himself be honest and always shows a just regard for the feelings and rights of others, for an examiner to gain the confidence, respect and assistance of family physicians and policy holders as well.

Sometimes, in small towns where the insurance work is small and the contact of examiners and attending physicians is complicated and close, conditions are such that the best results demand the presence of the family doctor when the examiner conducts his investigation.

In the case of liability insurance the position is entirely changed. The policy is held for the protection of one individual against damage which may result to another and the injured party is not bound by any of its conditions, and is in no way obliged, unless he sees fit, to allow any examination except by his attending physician.

Here, as much as ever, will his reputation for square dealing help the examiner and, frequently, enable him to secure through the attending physician an opportunity to make an examination of his patient.

In many of these cases no examination is allowed or, if permitted, it has to be made in the presence of the doctor or an attorney or both, and is limited to a greater or less degree by the advice of counsel acting in the claimant's behalf.

Physicians who do not lend themselves unduly to the support of their patients' claims are usually willing and glad to make it possible for the examiner to see the injured party and they are willing to assist in every way in their power to enable the truth to be known.

Fortunately, the majority of attending physicians are fair minded, and when convinced that their patients will be treated with due regard to their feelings and rights, they are only too glad to facilitate all efforts toward a thorough and impartial investigation.

It is, then, largely a case of how the examiner approaches an attending physician or his patient which determines the reception he is given and the information he is able to secure. Examiners and family doctors have duties toward each other which can only be properly estimated when they are both guided by a conscientious desire to do toward each other as they would be done by when their positions are mutually changed.

YOUNGSVILLE, PA., July 31, 1909.

DR. CHAS. EMIL BRACK, Baltimore, Md.

My Dear Doctor.—Enclosed please find check for \$2.00 for the JOURNAL. I don't suppose us old fellows of the class of '81 would recognize the modern College of Physicians and Surgeons, but our hearts have been with you all of this time. I am wondering where all of that 125 who "came through that time, are, and how they like it." I have enjoyed the practice very much and would do the same thing if I could go back again. I graduated on March 1, 1881, and located at Kinzua, Pa., March 31, following, where I remained till November 1904. Lumbering was the greatest industry and when the timber was all gone and I had gathered a little of the "cream" I moved to this thriving Borough, where I have a nice location and am happy in my work. The other day I went into our County Medical Society a little late and one of the fellows remarked "Here comes one of the old war horses." It almost shocked me for it sounded as though they thought I was getting old. May be I am, but I feel young. I have a good wife, two daughters and one son. The latter is practicing medicine at Brown Station, Ulster Co., N. Y.

I would be so glad to hear from our class, especially those who remember me.

Very truly yours,

J. J. KNAPP.

P. S.—I found a rare case June 5, a lovely baby girl, but without the left patella. The leg and toe were turned up on the abdomen, there was a crease where the patella should be and it was with difficulty that the leg could be flexed at all. I put on a splint with the knee slightly flexed and each day had the knee massaged at three different periods of 15 minutes each and passive flexion used, never allowing the leg to any more than straighten. There must have been a rudimentary patella, as we now have a patella over half as large as the other and the leg has no inclination to extend beyond normal, and I am expecting a perfect result. The case is ten miles from here and I have only seen it twice, but hear from it often.—J. J. K.

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THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE TESTIMONIAL TO DR. KEIRLE.

One of the pleasantest features of the year is the testimonial to Dr. Nathaniel Garland Keirle, which took the form of a testimonial volume containing Dr. Keirle's collected writings and studies on rabies. The book also includes an introduction by Dr. Wm. H. Welch and a biographical sketch of Dr. Keirle by Dr. Harry Friedenwald.

The book and also a dinner were gotten up by a committee composed of Drs. Harry Friedenwald, John W. Chambers and A. C. Harrison. One hundred and ten of Dr. Keirle's medical friends, chiefly though not exclusively his students and associates at the College of Physicians and Surgeons, subscribed to the volume, which will be presented to the subscribers and also to all the important medical libraries.

The following is the graceful address to Dr. Keirle which was read by Dr. Harry Friedenwald at the close of the dinner when presenting to Dr. Keirle a handsomely bound copy of his writings:

"The committee publishes this collection of your writings on rabies, both for their intrinsic worth and as a mark of the esteem and admiration of a large number of your friends and colleagues whose names are given below.

"Your work as a teacher, the scientific stamp of your studies and pub-

lications, but most of all your painstaking and successful labors in the preventative treatment of rabies have merited the highest approbation. Your care and accuracy, your untiring persistence and unwillingness to accept conclusions until thoroughly proved have characterized you as a true scholar and an example of devotion to science. You have not been spared disappointment and you have suffered the greatest of sorrows, but you have borne them with heroic fortitude. Your friends have shared them with you as they likewise take pleasure in your labors and success. For them all, we express the wish for your continued health, vigor and strength steadfastly to pursue your beneficent work.

"In presenting you with your writings in this volume, we feel that in honoring you we are showing honor to a true physician, a real scholar, a rare, cultured and noble man."

The articles published in the book are as follows:

The bacillus of rabbit septicemia obtained from the medulla oblongata of a supposed rabid dog.

Rabies in the mouse, together with a simplified experimental method for the detection of rabies.

Rabies: A report of the autopsies on four recent cases.

The technique of the Pasteur anti-rabic treatment.

Experimental rabies, with especial reference to the Baltimore City cases.

Practical notes relative to rabies.

The articles on rabies from the Twentieth Century Practice.

The fallacy and inutility of the so-called "rapid diagnosis of rabies."

Report of 1000 cases treated at the Pasteur Department.

The period of incubation.

The results of the preventative treatment of rabies.

Practical notes on the treatment of those bitten by supposedly rabid animals.

Accidents paralytiques.

The dinner was given the evening of October 11, which was the day following the 76th anniversary of Dr. Keirle's birth, and was held at the Maryland Club. Besides Dr. Keirle there were present the following

guests: Hon. James Gorter, Drs. S. M. Free, J. C. Bloodgood, J. H. Branham, J. Friedenwald, A. Cotton, G. W. Mitchell, W. W. Requardt, H. H. Haynes, F. C. Bressler, T. L. Richardson, A. C. Barrett, J. W. Chambers, A. P. Herring, H. G. Beck, C. W. G. Rohrer, W. R. Stokes, J. W. Funck, H. H. Biedler, C. F. Bevan, G. W. Dobbin, E. N. Brush, T. C. Worthington, J. D. Blake, W. S. Gardner, David Street, C. H. Jones, W. S. Thayer, A. Samuels, H. K. Fleckenstein, W. E. Miller, W. E. Magruder, A. C. Gillis, J. Ries, A. C. Harrison, W. F. Lockwood, A. McGlannan, W. B. Wolf, W. S. Rosenthal, J. Ruhräh, W. S. Simon, F. D. Sanger, G. M. Linthicum, W. H. Welch, H. Friedenwald.

At the close of the dinner, Dr. Harry Friedenwald, acting as toastmaster, presented the testimonial volume to Dr. Keirle and then later called upon the following gentlemen, all of whom responded in short but very pleasant addresses which concerned Dr. Keirle as physician, scientist and man: Drs. H. Friedenwald, A. C. Harrison, G. M. Linthicum, J. D. Blake, W. R. Stokes, W. H. Welch and Hon. James Gorter.

Taking it all in all the testimonial was one of the most graceful and the most pleasant that it has been our good fortune to witness. It is a matter of regret that there was no stenographer present to take down the many delightful things said about Dr. Keirle, so that the JOURNAL could reproduce them for the benefit of its readers. The JOURNAL wishes to assure Dr. Keirle that all of the alumni of the College echo the sentiments that were so ably expressed on the occasion of his dinner.

POST-OPERATIVE THROMBOSIS AND EMBOLISM.

Phlebothrombosis and acute gastric dilatation are the most serious complications of aseptic operations. Various methods of preventing thrombosis and embolism have been proposed, the one most urged is getting the patient out of bed soon after operation. In some clinics this has been pushed to an extreme degree, but unfortunately the method can be applied only to a class of patients in which the complication is rarest.

The thrombosis of aseptic operations is metastatic, the veins of the left leg being especially prominent as the seat of the lesion. The cause is

unknown, but it is probably some infection, either from a flaw in the asepsis, or from gastric and intestinal stasis. Embolism is a frequent sequel of this phlebothrombosis. Many cases of post-operative pneumonia are embolic. There is no question but that the embolism is the dangerous factor in the course of the complication. Pulmonary embolism, being rapidly fatal, occasionally is the cause of sudden death in a convalescent patient.

The prevention of thrombosis seems to depend on perfect asepsis, and particularly on careful and thorough cleansing of the intestinal tract before any elective operation. Embolism was the cause of death after operation for the relief of obstruction, in two cases of chronic sigmoiditis with stricture that came under my observation. When thrombosis has occurred the patient must be kept absolutely quiet, and this is done most effectually by small doses of morphia. The heart's action may require stimulation, especially when a large vessel has been obstructed.

Operative removal of the clot is to be considered. The vessel may be opened, the clot removed and the vessel wall sutured. When, however, the clot is in an artery and the intima shows signs of injury or disease, it becomes necessary to resect that portion of the vessel, and unite the ends either directly, or by the insertion of a segment of a vein. A very good method for removing the clot is to make a small lateral incision into the artery above or below the obstruction and through this insert a firm rubber tube, and then draw out the clot by suction.

In Trendelenburg's clinic a clot was taken from the pulmonary artery and the patient recovered. The vessel was exposed by making an osteoplastic flap over the base of the heart and the clot aspirated through a small incision in the vein. This is a rather formidable operation to contemplate, but when the patients are in a desperate condition any chance should be taken to relieve them. Rapidity is essential. Trendelenburg gives twenty minutes as the limit of time in which recovery is possible. Every house surgeon, therefore, should practice this operation on animals until he is familiar with all the details of the technic. A. McG.

1895.

In 1910 the class of '95 will have its 15th anniversary, and it has been suggested that a class re-union be held at the time of the college commencement about the first week in June.

Dr. E. A. Bowerman, our first honor man, has promised to deliver the annual address at the alumni meeting. This will take place at night in the college building, and will be followed by a lunch and smoker.

The following morning will be devoted to inspection of college and hospital to give our alumni an opportunity of comparing what was with what is. A luncheon at noon to be followed by sight seeing, etc.

The commencement exercises at night to be followed by the banquet. It is estimated that the program, including banquet ticket, can be arranged to cost about \$5.00.

It is absolutely necessary that the committee of arrangements should have a working estimate of the number to be provided for and we would earnestly request those who contemplate taking part in this re-union to send in their names at once.

If the number of acceptances does not justify the holding of a re-union we will have sufficient time to cancel the arrangement and so notify our class-mates.

Drs. Alexius McGlannan and Chas. E. Brack have the arrangements in hand. Communications should be addressed to Dr. Chas. E. Brack, 500 E. 20th Street, Baltimore, Md.

DR. FERDINAND SAUER, '01.

JERSEY CITY, N. J.

Dr. Ferdinand N. Sauer has been mentioned as a candidate for the Republican nomination for Mayor. He was born in the Third Ward of Jersey City on February 2, 1874, and is a graduate of Public School No. 2, the New York College of Pharmacy and the College of Physicians and Surgeons. He was Deputy Health Officer under the Fagan administration and superintendent of the City Bureau of Contagious Diseases. He is a certified State health officer. Through his efforts the local Contagious Disease Hospital was established. It is said to be the best equipped hospital for contagious diseases outside of Boston. Dr. Sauer established the Pasteurized milk plant in Jersey City—the first municipal plant of its kind in the United States.

Obituary.

DR. GEORGE P. PHILLIPS, '90, died at his home, Early Grove, Miss., July 14.

DR. WILLIAM E. MOORE, '81, formerly of Derby, Iowa, died suddenly in his office, at Lincoln, Neb., from endocarditis, aged 57.

DR. WALTER H. VINAL, '97, a surgeon of volunteers during the Spanish-American War with service in Cuba, died at his home in Hamilton, near Baltimore, September 27, from pneumonia, aged 35.

DR. GEORGE H. BERRY, '48, Washington University, Baltimore; Georgetown University, Washington, D. C., '50; a member of the Somerset County (Md.) Medical Society; died at his home in Hopewell, September 10, from rheumatism, aged 84.

DR. GEORGE LAFAYETTE MARTIN, '77, a member of the South Carolina Medical Association; for eight years supervisor of vaccination and quarantine for the Piedmont section of South Carolina under the State Board of Health, died at his home near Greenville, September 16, aged 55.

Dr. J. H. Crockett, '79, the well known physician, died at his home, Tazewell, Va., July 12. His death was caused by diabetic coma, superinduced by a carbuncle on his neck from which he had suffered for two weeks or more. Owing to his physical condition his friends were apprehensive from the beginning of the growth of the carbuncle, and their worst fears were realized.

Dr. Crockett was born and reared in Tazewell County. He was 56 years of age. He graduated with honors from the College of Physicians and Surgeons, Baltimore, in May, 1879. His entire professional life was spent in Tazewell County—beginning on Clear Fork, then in Burke's Garden, where he married his wife, Miss Ellan Peery, thence after a few years, to Graham, where he formed a co-partnership with Dr. R. M. Witten, and afterwards with Dr. C. W. Greever, and after several years of successful practice, moved to Tazewell, and a year and a half ago, formed a co-partnership with Dr. Samuel Bowen, which co-partnership existed at the time of his death.

Besides his wife he leaves three children—one son and two daughters to mourn the loss of an affectionate husband and indulgent father.

Personal Notes.

DR. C. A. FLOWERS is doing a regular practice at Columbia, N. C.

DR. JOHN RUHRÄH, '94, after a two months' trip through Spain and Italy has returned to Baltimore.

DR. F. W. STEINER, '07, has been practicing for a little more than a year at Havre de Grace, Md., and is doing well.

DR. W. R. ARNOLD, '06, has given up his practice at Lynch's Station, Va., and after a visit to Baltimore he will select another location.

DR. LATIMER P. JONES was married to MISS MARY LOUISE WARTHEN, on Wednesday, August 4, 1909, at Baltimore, Md., and they will make their home at Pennsboro, W. Va.

DR. DON C. HUGHES, of Findlay, Ohio, Chief of the Medical Department of the Woodmen of America, has recently married and will continue to reside at Findlay, Ohio, where he has an interest in one of the hospitals.

DR. W. PAGE MCINTOSH, '82, is now the surgeon in charge at the Marine Hospital, Baltimore. Dr. McIntosh spent two years in hospital work after his graduation and then went directly into the Marine Hospital service. During this long period he has had many important assignments and is now ranking among the seniors in the service.

The high standing that the graduates of the College have taken before the State Board is having the effect that was easily foreseen. The applicants for entrance to the freshman year this fall are so numerous that it is no longer a question whether the class will be full, but a question as to just how many will not be taken on account of earlier matriculants filling the class up to the limit.

DR. W. E. FITCH, '01, has recently been made editor of pediatrics. This journal was founded by Dr. Dillon Brown, of New York City, and,

under his capable efforts, became a most useful journal for this special line of medical practice. With Dr. Fitch at the head of it, we feel sure that the new journal will take a very prominent place in the medical literature of this country.

DR. A. C. GILLIS has been appointed superintendent of the Mercy Hospital, and has been devoting his energies to completing the organization of the medical staff and making arrangements for the keeping of more complete records, with improved methods of filing, so that the records will be more available than formerly. A branch exchange telephone has been established in the college and hospital, which will greatly facilitate the work of all departments.

DR. H. M. COHEN, '96, who spent several years in the army in the Philippines, and left the army with the rank of Captain of Volunteers, after practicing for some time in Baltimore, has recently been appointed Assistant Surgeon and First Lieutenant in the Medical Reserve Corps of the army and will be stationed at Newport, R. I. The readers of the JOURNAL will recall with much pleasure a number of papers by Dr. Cohen that have appeared in these pages from time to time.

Addresses or information about the following is desired by the librarian, and will be greatly appreciated:

CLASS OF '76: C. D. East, T. G. Edmiston, John E. Garner, John D. Gilbert, E. B. Harris, H. H. Marshburn, F. J. Moody, F. J. Reidt, G. Waldrop, E. F. Wayman.

CLASS OF '77: John R. Boyd, Wm. G. Coe, Frank P. Cracraft, John L. Dunlap, Wm. Shields, Rufus H. Smith.

CLASS OF '78: U. S. Hassell, Henry C. Hopkins, W. W. Kidd, W. R. Krissinger, Geo. Byron Lyman, Geo. B. McCorckle, Thos. M. Scott, John J. Williams.

Correspondence.

LEXINGTON, N. C., March 5, 1909.

Dear Doctor Brack.—You do not know me personally, but in my visits to the C. of P. & S. I have seen you and talked with you, quite much to my entertainment and information. We have several excellent C. of P. and S. men now at work here in this county. There is W. Lee Hill, M. D., Lexington, Route 4, who has long been doing well in the upper part of our county. There is Dr. W. J. Vestal, of away back in the eighties, doing a splendid practice here in our little town. My brother and partner, Dr. Joel Hill, further back yet than Vestal, in the early eighties, is spending the winter in the far west on account of ill health. And last, but by no means least, there is my friend, Dr. Chas. M. Clodfelter, doing an enormous practice here, always facetious, always after the prettiest girls of all, is at last, so rumor says, wounded well nigh unto death by one of Cupid's well-directed shots, and will soon take unto himself the lost rib, the most crooked bone in the body, which was taken from the side of Father Adam, in the Garden of Eden in the years long ago. And as for me, I am the most humble and unpretentious of all of that greatest of Galaxy of particular and brightest stars who walked out of the old College of Physicians and Surgeons, in the memorable class of '92 and '95.

Yours very truly,

D. J. HILL.

EL PASO, TEXAS, August 5, 1909.

DR. CHAS. EMIL BRACK, Treasurer.

Dear Doctor.—Enclosed you will find my check to cover my dues to the JOURNAL for 1909. I enjoy each and every number, and am always glad to hear what's going on at the old college. I had fully intended coming east this summer and doing some post graduate work, but my plans were upset by my being appointed Assistant County Health Officer for this county, and that has made my summer quite a busy one. We have two other P. and S. men here, and they are both doing very well. Things in the west are picking up quite steadily, and we expect to have a great time here during the coming fall when our fair takes place, also

the meeting of the two presidents. Would be mighty glad to have any of my former professors come out and see us, as I am quite sure you would like our city and its people. With my kindest regards to all who ask after me and trusting the coming year will be a successful one for our school, I am,

Sincerely yours,

FRENCH S. CARY.

WELCH, W. VA., May 31, 1909.

DR. CHAS. EMIL BRACK, BALTIMORE, MARYLAND.

Dear Doctor.—Enclosed you will find \$1.00 for renewal of my subscription to the ALUMNI JOURNAL.

I read the JOURNAL with great pleasure and enjoy the personal notes and correspondence very much also.

I might add that I am located at Welch and doing very well, and also, that I was in Baltimore in April attending the wedding of my sister. I visited the College at that time and was very glad to see that it was going on so nicely.

On May 5 I was married to Miss Nellie Leckie, the daughter of Mr. Wm. Leckie, superintendent of the Jed Coal & Coke Co., at the latter's home; after which, Mrs. Kell and I spent a short time touring Virginia and are now at home at Welch to our friends and to any of the P. and S. Alumni who may wish to call.

Sincerely,

S. J. KELL.

SOLVAY, N. Y., May 31, 1909.

Dear Doctor Brack.—I am sending you \$1.00 for subscription to the ALUMNI JOURNAL. It comes to me as a bright spot on a homesick day, and I enjoy its contents very much. I have never had the pleasure of visiting my alma mater since I graduated in 1893, but my thoughts have often been there in the years that have passed, and I expect some time to see it again in reality.

In reading the JOURNAL I forget myself for the time, and it takes me back to the scenes of my college life, amid scenes of hard work and happy

expectations. I also note the changes in and about the College, and when I note the good and true men who have gone to the great beyond, it tells me that life is but a short duration here.

I note occasionally a class re-union, and it would please me much to have a re-union of the class of '93. Would be glad to have an expression from the "boys" on the subject. Wishing you and all connected with the College the best success, I remain,

Yours fraternally,

W. P. KANAR.

MACON, N. C., January 25, 1909.

DR. WILLIAM S. GARDNER, BALTIMORE, MD.

My Dear Doctor.—I notice in the JOURNAL OF THE ALUMNI ASSOCIATION OF THE P. S. an account of my death, which I am happy to say is an error. I am still practicing medicine at Macon, N. C. I have never left the "Old North State" and expect to die within her borders. I hasten to make the correction for the benefit of my friends in other States.

Hoping to meet you at the next Alumni meeting and wishing you a prosperous new year, I am,

Fraternally yours,

MARK P. PERRY.

SOMERVILLE, N. J., August 2, 1909.

CHARLES E. BRACK, M. D., Baltimore, Md.

Dear Doctor.—Your timely remarks in the July number of the JOURNAL on "Class Reunions" ought to be considered by every alumnus. It was certainly disappointing after thinking and planning for a reunion of the class '04, for a year and making every effort to get there to find only one member of our class present, excepting myself, who resided out of Baltimore.

I hope the spirit of the class '04 has not vanished in so short a time as five years.

Perhaps many of our classmates were uncertain, as myself, whether the reunion was to be held. There was no final notice sent out of the

class meeting, the only letter I received, was asking if such a reunion was advisable. It was a pleasure to meet some of the boys anyway and to see the faces and receive the greetings of so many of our honored faculty.

Enclosed, find check for two dollars. With best wishes for our Alma Mater and the ALUMNI ASSOCIATION JOURNAL, I remain,

Yours respectfully,

LANCELOT ELY, '04.

ONEIDA, N. Y., May 31, 1909.

DR. C. E. BRACK.

Dear Doctor.—Enclosed find one year's subscription. I have enjoyed each number of the JOURNAL and was much interested in Prof. Simon's, Cohen's and McGlannan's contributions in this issue.

Very truly,

E. H. CARPENTER.

SALT LAKE CITY, June 15, 1909.

DR. CHAS. E. BRACK, BALTIMORE, MD.

Dear Doctor.—Inclosed please find my check for \$1.00 in payment of JOURNAL.

If all goes well, I'll pay you a visit in the course of three or four months.

Remember me kindly to all the doctors, especially Doctors Gardner, Harrison, Ruhräh, McCleary, etc.

Yours truly,

ROSS ANDERSON.

GILBOA, N. Y., September 10, 1909.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Find enclosed check, \$1.00, to pay my dues as per statement. Am always glad to get the JOURNAL. The article in the July number by Dr. Edward H. Ewing was of great interest to me, especially

the part relative to infant feeding, where the baby and calf are reared on the same diet. I see the same thing in my practice.

Am well and busy and am living in hopes of finding time to visit Baltimore, and look over the old grounds again.

Yours with best wishes. I remain

Truly,

E. S. PERSONS, '92.

SOUTH ORANGE, N. J., August 19, 1909.

Dear Doctor Brack.—Enclosed please find my subscription for two years to the JOURNAL, which I enjoy very much. My brother, Dr. Fredk. Knowles, has taken a trip to Europe this summer with his bride.

With kind regards and best wishes.

Sincerely yours,

FRANCIS E. KNOWLES.

BUTLER, PA., April 15, 1909.

DR. CHAS. E. BRACK, BALTIMORE, MD.

Dear Doctor.—I inclose herewith check for three dollars, which I believe will put me a little ahead on subscription to the JOURNAL. Am getting along first-rate. Am president of the Butler County Society and surgeon to the General Hospital here. Also belong to State and three national societies. I want Drs. Chambers, Gardner, and Friedenwald, three honored friends of mine, to know that I am still on deck.

Very truly yours,

L. L. DOANE.

BLUEFIELD, W. VA., August 7, 1909.

DR. C. E. BRACK, Baltimore, Md.

My Dear Brack.—I herewith enclose check for 3 years' subscription to the JOURNAL. I am always glad to receive it and hope the publication may ever continue. I would certainly like to attend a '95 class reunion in 1910, and hope you may be able to get the boys together. What has become of Bowerman, Moffit, Shultz and Larter? I enclose the an-

nouncement of Dr. J. H. Crockett's death and you can publish what part you wish.

If you or any of the boys ever pass through this neck of the woods, stop off and see me.

Yours truly, etc.,

THOS. E. PEERY, '95.

HAGERSTOWN, MD.

Dear Doctor.—Can you not arouse enough interest in the class of '75 to hold a re-union at the next commencement? There are so many of the old boys that I would like to see again. I have been in Hagerstown for eleven years doing special work on ear, nose and throat. Regret that arrangements made to go to Atlantic City on the 7th will prevent my being in Baltimore at commencement this year.

L. H. KELLER.

LEXINGTON, N. C., August 19, 1909.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor Brack.—Please find enclosed check for \$2.00 for arrears to the JOURNAL. I enjoy my JOURNAL so much. Was glad to see the Alumni reunion at Atlantic City so well attended, but was sorry not to see any of my old class mates of '05 not there. Have just received a message that Dr. C. D. Christ, of class '05 is ill with appendicitis at Baltimore City Hospital. Hope for a speedy recovery.

I hope in your next issue of the JOURNAL to hear from some of '05 P. and S. boys.

With best wishes for yourself, Mr. Annen, Dr. Bevan and all my old Professors.

Yours fraternally,

CHAS. M. CLODFELTER.

NEW BOOKS.

Park, Davis & Co. have recently put out two volumes that are of particular interest to physicians.

"Serums and Vaccines," 52 pages, is handsomely printed on white enamel paper and profusely illustrated. There is a brief chapter on the origin and development of biological therapeutics. Then follow chapters on serums—anti-diphtheritic, antitetanic, antistreptococcic, antigonococcic, antitubercle and antivenomous; on tuberculines and on vaccines.

"Manual of Therapeutics," 643 pages, is well printed and handsomely bound in flexible leather. In the first section there are tabulated a series of the elusive facts that every physician is supposed to be familiar with, but which too often have grown hazy. The second section is devoted to therapeutic suggestions. The bulk of the book is devoted to *Materia Medica*. So that we have in this little volume a means of seeing at a glance a great variety of medication. By referring to the chapter on Therapeutic Suggestion and to the larger chapter on *Materia Medica* one can find quickly just what drugs, or what preparations of drugs, are available.

Both these volumes will be valuable additions to every physician's library. Both are sent free on application to Park, Davis & Co., Detroit, Michigan.

The President of the American Gynecological Society has appointed a committee to report at the next annual meeting in Washington, on the Present Status of Obstetrical Teaching in Europe and America, and to recommend improvements in the scope and character of the teaching of obstetrics in America.

The committee consists of the Professors of Obstetrics in Columbia University, University of Pennsylvania, Harvard, Jefferson Medical College, Johns Hopkins University, Cornell University and the University of Chicago.

Communications from anyone interested in the subject will be gladly received by the Chairman of the Committee, Dr. B. C. Hirst, 1821 Spruce Street, Philadelphia, Pa.

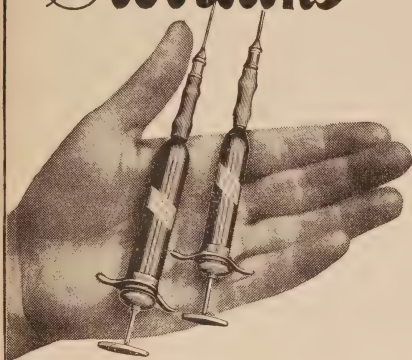
ACCURACY IN THERAPEUTICS.

The efficiency of a medicinal agent cannot be determined by mere physical appearance. Two specimens of fluid extract of digitalis, for example, may look precisely alike. One, upon administration, may exhibit a wholly satisfactory therapeutic action; the other, given under precisely the same conditions, may prove to be practically inert. Lack of uniformity in the crude drug, and absence, on the other hand, of an adequate method of assay, account for the singular discrepancy. And this serves to show the necessity of standardized remedial agents if we would proceed in the treatment of disease with any assurance of success. It emphasizes, too, the futility of trusting to chance that the extract of a crude drug contains what the practitioner supposes it to contain and what it ought to contain.

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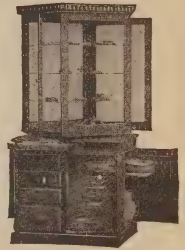
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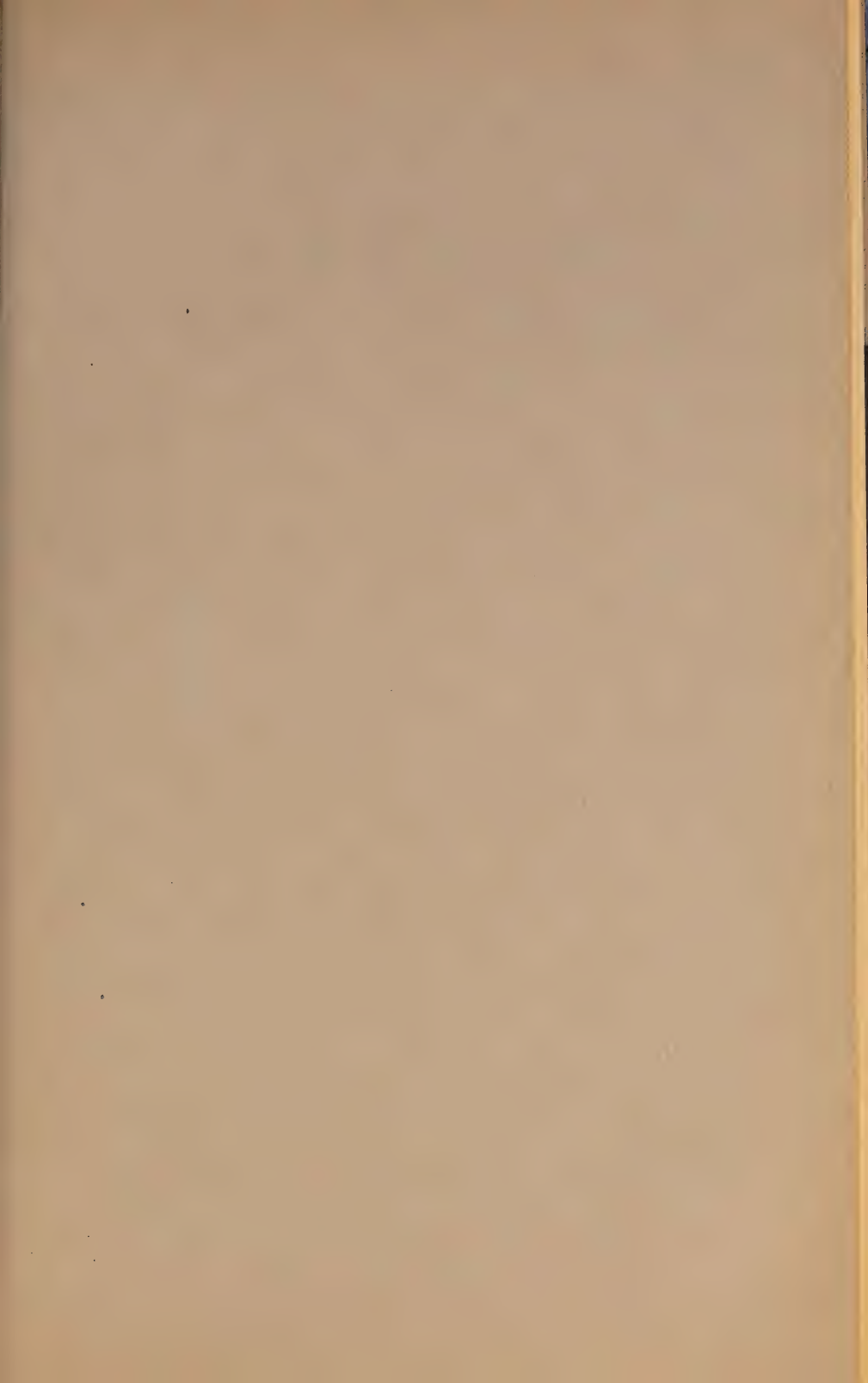
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THE JOURNAL
OF THE
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BALTIMORE.

Vol. XII

No. 4

JANUARY, 1910

PUBLISHED AT
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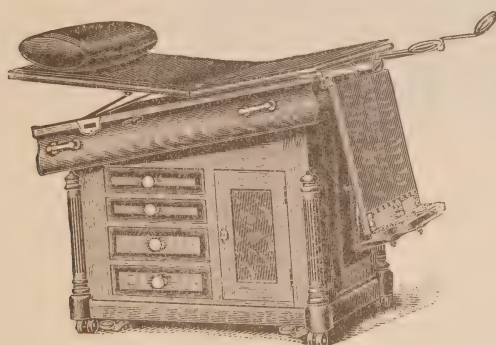
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COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE PROGRESS OF MEDICINE.*

BY WILLIAM ROYAL STOKES.

Mr. President, Members of the Faculty and Gentlemen:

In delivering the opening address for the college year, I thought that it might be fitting to speak upon the subject of "The Progress of Medicine," and I have selected this topic especially for a personal reason. I have not forgotten my own impressions when I began the study of medicine, and these ideas might be expressed in the following manner:

When I entered upon the study of anatomy I simply dismissed the subject of the development of this science (if I ever thought of its development at all) with the impression that it was compiled and written by a man named Gray, and I often wished that he had not been so long-winded. Yeo was to my mind the Alpha and Omega of physiology, and the authors of my various other text-books were the creators and expositors of their subjects to me.

Methods of teaching have changed, even since my student days, and I do not mean to intimate that our students of to-day are as ignorant of the history of medicine as was I. And yet I believe that few young men really appreciate the fact that our present knowledge is a heritage from the ages; a gradual development from century to century.

It seems to me that this idea is best expressed by the lines of Lord Tennyson in "Locksley Hall":

Yet I doubt not thro' the ages one increasing purpose runs,
And the thoughts of men are widen'd with the process of the suns.

* Opening address at the College of Physicians and Surgeons for the session of 1909-1910, October the first.

In this address I shall endeavor to follow the thread of this "increasing purpose" through the ages, and trace out the widening of some medical thoughts from ancient times until to-day.

In order to follow the evolution of medicine it is necessary to begin with anatomy, since this study formed the basis of all the other essentially medical branches. We can dismiss the fragmentary knowledge of the Egyptians and other ancient nations, and begin with the work of Aristotle, the teacher of Alexander the Great. This great philosopher, living at the court of Philip of Macedon, and afterwards at Athens from 384 to 321 B. C., laid the foundation of anatomy in his "History of Animals," a translation of which can be purchased at any book store for a dollar and a quarter. We can follow the "increasing purpose" of several different threads of medical thought from this book and we should begin with anatomy.

The munificent Alexander paid men from all over Greece and Asia Minor to bring animals to Aristotle for dissection, and this great observer recognized the origin of nerves from the brain, and the optic nerve. He described the common origin of the vessels from the heart, and distinguished between arteries and veins. He also gave a good description of the ureter, uterus, and various portions of the skeleton, but his descriptions were based upon the dissection of animals; he was, therefore, the founder of comparative anatomy.

After the conquest of Egypt and the death of Alexander, his successors who ruled Egypt first allowed physicians to dissect human bodies, and it is said that at times human vivisection was performed. The general culture fostered by the Ptolemies encouraged two great anatomists in Alexandria about 300 B. C., and the lives of Herophilus and Erasistratus are full of interest. The name of the former is preserved to-day in the "Torcular Herophili," and he also described the calamus scriptorius, the fourth ventricle, the liver, the Fallopian tubes, the retina, and various other arteries and veins. Erasistratus distinguished between motor and sensory nerves, and described accurately the ventricles and convolutions of the brain, the trachea, and certain portions of the heart. It would seem that such knowledge would have been treasured for future generations, but about 117 B. C. Ptolemy Physon drove all of the learned men

from Alexandria, and the burning of the great Alexandrian libraries by both pagans and Christians completed the work of destruction.

And now for many centuries the study of human anatomy was neglected, and during the middle ages the ban of the church was laid upon any one who dared desecrate the earthly temple of the soul by endeavoring to learn its secrets. Certain surgeons may have occasionally dissected dead bodies, but it was not until 1316 that Mondino de Luzzi, the Professor of Anatomy at Bologna, ventured to publish his "Anatomy of the Human Body." This book merely described the appearance of the internal viscera, and Mondino dared not open the skull, since such conduct would have rendered him a promising candidate for Hades.

But a greater than Mondino was soon to appear, and as modern anatomy begins with this man, we must consider for a moment the career and work of Andreas Vesalius. He was born in 1515 at Brussels, and lived during the reign of Charles V, of Spain, and Phillip II. These were stirring times, and human knowledge was increasing by leaps and bounds. Cortez and Pizarro were opening up Spanish America. Henry VIII was forming a new religion in England, while Luther had already started the Reformation in Germany. Calvin was establishing his great politico-religious rule in Geneva, and Loyola had just founded the Society of the Jesuits. Michael Angelo and Titian were producing immortal paintings, Copernicus had opened up astronomy as a new science, Gutenberg had given printing to the world, and Charles V, of Spain, was ruling the greater part of the old and new worlds.

In 1543 Vesalius published his great work on anatomy, called "Fabrica Humani Corporis" or the "Structure of the Human Body," the foundation of anatomy for all time.

We can only consider briefly the main points in Vesalius' career, and it is sufficient to say that coming from a long line of medical ancestors, he received a good education at the University of Lovain, and then studied medicine at Paris under the great anatomist Jacobus Sylvius. He was soon elected Professor of Anatomy at the University of Padua by the Senate of Venice, where he taught anatomy for five years.

The important feature of his teaching and book was the placing of anatomy on an experimental basis, where all descriptions and statements must be based upon personal dissections and observations. Up to this

time physicians had depended upon the partially fanciful descriptions of Galen, and it was the duty of Vesalius to combat and disprove these statements, although often meeting with the greatest opposition from his contemporaries, especially Sylvius, his old teacher, who believed that the development of anatomy ceased with Galen. As instances of the difficulties of his task he failed to convince his opponents that there was no large bone in the heart, that the bones of the hand contained marrow, and that the sternum consisted of three instead of seven bones.

To describe his book would be too long a task, but he was the first to illustrate anatomy by beautiful wood-cuts, and many of the fine illustrations in Gray are based upon the highly artistic pictures in the "Fabrica." In this book he described practically all the muscles, and bones, many of the veins and arteries, the five ventricles of the brain, the anatomy of the ear, and the structure of the various cavities and their viscera, including many important features of the anatomy of the brain. I trust that you will still treat his memory with some charity, when I inform you that he was the first man to describe the sphenoid bone.

To trace out the far-reaching results of the work of Vesalius is to write the history of anatomy. His descriptions have been multiplied, but anatomists and surgeons to-day still use the recorded knowledge of Vesalius more than any other one or perhaps ten men, for his was one of the "master minds of medicine."

I wish I could end by describing his happy life, but in five years he made so many enemies by his fearless investigations, that after a particularly vicious attack upon him, he tore up many important manuscripts recording his discoveries, and accepted the office of Court Physician to Charles V at Madrid. Here his investigations ceased, but he still later made many enemies, in that bigoted court of Phillip II. Things at last became so intolerable for him, that to escape persecution he embarked for a pilgrimage to Jerusalem. Legend has it that he was compelled to make this pilgrimage as an expiation for having performed an autopsy by accident upon a young nobleman, whose heart was still beating when the body was opened up. The former explanation is probably correct. On returning he was shipwrecked, and landing on the island of Zante, he died from neglect. This great genius in five years produced a work which has remained as the basis of anatomy for centuries.

And now we must trace out another thread in this "increasing purpose," and at first sight this may seem to lead us astray. If we persevere, however, it will direct us to some of the most important discoveries in physiology, and their application to the cure of disease.

Although Aristotle described the heart from an anatomical standpoint, yet we must journey on much further to A. D. 131 to 210, which corresponds to the life of Claudius Galen, of Pergamus. This great Roman physician studied at Alexandria, in Egypt, and later practiced at Rome. He wrote on all subjects in medicine, but we can only consider his views concerning the circulation of the blood.

He believed that the food absorbed from the intestine was carried by the portal vein to the liver, where it was turned into blood, and received certain nutritive properties known as "natural spirits." It was then carried from the liver by the vena cava to the right ventricle where a portion of it passed through the septum by invisible pores to the left ventricle. Here a most important change took place. As the heart expanded it drew air into the left ventricle from the lungs by means of the "vein-like artery" or pulmonary vein. This vein connected in some mysterious way with the trachea into which air was drawn from the atmosphere by the inspiratory movements of the chest.

The blood from the right side of the heart flowed through the veins to the tissues for nutrition, and then ebbed back, and this constant ebb and flow nourished the tissues. The blood in the left ventricle mixed with air became indued with "vital spirits," and such blood was also distributed by the aorta and its branches to all parts of the body by ebb and flow. This flow conveyed the "vital spirits" to the tissues, and these were most important for the actual maintenance of life. The pulmonary vein also bore certain fuliginous or waste spirits which had been extracted from the crude blood which passed through from the right to the left ventricle, and these waste spirits were eliminated by the lungs. Such was the physiology of the circulation taught even by Vesalius, and we can now inquire how the true facts in the case became gradually known.

The first link was furnished by the theologian, Michael Servetus, who simply studied physiology for the purpose of studying the body of man and the spirit of man in order to comprehend the spirit of God. In his "Restitution of Christianity" he denied that blood passed through the

septum from the right to the left ventricle, and he followed this with an accurate description of the lesser, or pulmonary circulation. He showed how the blood passed by the pulmonary artery through the lungs, and to the left ventricle by means of the pulmonary veins.

This was in 1553 at Geneva, and you will probably remember how he and John Calvin differed about the Trinity, Servetus supporting the side of the Unitarian. In order to settle the argument, and relieve the mind of Servetus of any possible anxiety concerning these points, Calvin burned him and 1000 copies of his books in the public square of Geneva.

It would be most interesting to follow the arguments and statements of Columbus, Caesalpinus, and Cannanus, who wrote about the circulation, and this entire story is most interestingly told in Foster's "History of Physiology," but the master, who grasped the true facts concerning the circulation was Wm. Harvey, and his epoch-making work must now be considered.

This great investigator was born at Folkstone, England, in 1578, and was educated at Caius College, Cambridge. He then left England and entered the Italian University at Padua, where he studied medicine, and learned anatomy from the great anatomist Fabricius, who discovered the valves in the veins. His master failed to appreciate the use of these valves in preventing a backward flow of the blood in the veins, but it is said that pondering over these valves and their uses led Harvey to further studies of the circulation, after he returned to London, and lectured on anatomy at the College of Physicians.

We cannot follow all of the steps in this great discovery, but after observing the heart beating in many animals he concluded when the heart contracted, that it squeezed the blood into the arteries, which caused the arterial pulse. He next observed how the auricles receive the blood from the vena cava, and pulmonary veins, and he saw that the blood must pass through the lungs before it reaches the left side of the heart. He tied the vena cava and no blood passed through the lungs to the left side of the heart. He tied the aorta, and the lungs and heart became distended with blood. These, and many other experiments firmly established the true nature of the circulation, and the most important advances in physiology and medicine date from this demonstration.

Harvey had no access to a microscope, and was unable to explain how

the blood flowed out of the arteries into the veins. This link was supplied by the researches of the brilliant and versatile Marcello Malpighi, the Professor of Medicine at the University at Bologna. In studying the lungs of frogs he discovered the small channels which we now call capillaries joining the minute endings of the pulmonary arteries to the beginnings of the pulmonary veins. This was in 1661, and Malpighi also saw the red corpuscles, but mistook them for fat cells, and it was left to Leeuwenhoek, one of the fathers of microscopy to carefully describe these bodies in men and animals in the Philosophical Transactions of London in 1674.

Men's thoughts have widened rapidly in these nearly 50 years just described which followed Harvey's book published in 1628, and we have the circulation of small bodies called red blood corpuscles through the capillaries of the lungs admitted by the scientific world. And yet, what service did these corpuscles perform? What was their use? We must omit many interesting experiments, and advance exactly one century, to the year 1774.

In this year Priestley, the English clergyman, prepared oxygen, but failed to recognize its importance in respiration, or its place as an element and gas. It remained for Lavoisier, the great French chemist, during the next 15 years to accurately describe oxygen, and demonstrate its combination with the red blood corpuscles, and its relation to the body heat and oxydation of the tissues.

Priestley knew that air in a jar in which a candle had burned would no longer support combustion. Witness the patient experiments to restore the missing property. He placed a sprig of mint in a glass jar in which a candle had burned out and which he inverted in a vessel of water. After the plant grew for some months the air would no longer extinguish a flame. Every school boy knows now that oxygen is given out by plants, and Priestley had simply restored oxygen to the deoxydised air. He later decomposed mercuric oxide by means of the sun's rays from a burning glass, and obtained a gas very favorable for combustion. His mind was befuddled by Stahl's phlogiston theory, and he never knew that he had prepared oxygen, but merely believed that combustion abstracted a material called phlogiston from combustible materials, instead of adding a material which we now know as oxygen.

Lavoisier found the truth, for by extracting Black's fixed air or carbon-

dioxide from vitiated air, he still had a pure gas (nitrogen) which he called azotic air or air without life. By adding one-fourth part of fresh air, he found his mixture would support combustion. He compared respiration to combustion, and called his new gas oxygen.

Hear Carlyle in his "French Revolution" describe the untimely end of this great investigator.

"Lavoisier, famed chemist, shall die and not live. Chemist Lavoisier was Farmer General Lavoisier too and now 'all the Farmer Generals are arrested' . . . and shall . . . die. Lavoisier begged a fortnight more of life, to finish some experiments but 'the republic does not need such,' the axe must do its work." On the 9th of May, 1794, he rode in the tumbrils from the Conciergerie to the guillotine, and a mind was snuffed out that might have made many more important discoveries for the relief of human suffering.

And now we may ask if this "increasing purpose" and "widening of men's thoughts" has been of any practical benefit to mankind. The dependence of surgery mainly upon the dissections and description of Vesalius is obvious, and I was struck with this fact several days ago, when I examined a copy of his book printed in 1543. His plates are just as accurate and nearly as numerous as the older copies of Gray, and his "Fabrica" is really the basis of the anatomies to-day, which serve as guide books to all surgeons.

But these later discoveries are also of the greatest practical value. Without the proper description of the movements of the heart and blood that brilliant Irish school of medicine in Dublin lead by Graves, Stokes, and Corrigan could not have solved the problems of various diseases of the heart. We would not, therefore, be in possession to-day of means of prolonging and rendering comfortable many useful lives. The discovery of the combination of oxygen with the red blood cells teaches us to administer oxygen in pneumonia, when the lung is solidified, to relieve air hunger, and to bleed from the veins when they are overcharged with non-oxygenated blood in heart disease.

There are also other important fields opened up by the recognition of the oxidation of the tissues, for much of the important branch of physiological chemistry depends upon this fact. When you note the imperfect oxydation of urea by the diversion of ammonia in diseases of the liver, and

apply appropriate remedies, you see a practical result. When you save a woman from fatal convulsions during pregnancy by finding an increasing amount of ammonia in the urine, you are dealing with a problem of oxydation, and when the life of one of the most prominent of the world's physicists was prolonged for years by a proper regulation of the oxydation of sugar in diabetes, he had a brother scientist, the great Lavoisier to thank among others, for the completion of wonderful work on the spectrum.

I wish we could follow the development of embryology from Aristotle studying the chick to Malpighi's splendid description of the embryo, to De Graaf, who described the Graafian follicle of the ovary, and to von Baer, who discovered the ovum and founded modern embryology. It would be pleasant to follow surgery and obstetrics, and see how Semmelweiss founded clean obstetrics and saved thousands of parturient women by having physicians disinfect their hands with chlorine water, after coming from the dissecting room. But time presses, and we must very briefly consider one more subject before concluding.

The discovery of the circulation of the blood was also absolutely necessary in order to understand inflammation, and the work of Julius Cohnheim had of necessity to follow Harvey's observations.

This investigator was Virchow's assistant at the Pathological Institute of Berlin, and in 1867 he published the results of his studies on inflammation. The most important point consisted in showing that the white blood corpuscles wandered through the walls of the veins and capillaries during inflammation, and were set free in the tissues. Cohnheim, however, never clearly understood just why the white blood corpuscles emigrated into the tissues, and it remained for another man to show that this property is an extremely important protective power, and that the corpuscles wander through the vessels in order to attack and destroy bacteria.

Elie Metchnikoff, of the Pasteur Institute of Paris, has devoted his lifetime to the study of phagocytosis. He has shown how all varieties of animals overcome disease by including and digesting bacteria and other parasites which would otherwise destroy them. To-day we are learning to stimulate the white blood corpuscles in disease, and make them take up and destroy more bacteria. Medical literature is full of the favorable results of this so-called vaccine treatment in the infectious diseases.

Paul Ehrlich, of the Royal Institute for Experimental Therapy at Frankfort, and his followers have produced antitoxins for soluble poisons, such as diphtheria, lockjaw, snake venom, and other poisons, and they have also produced antagonistic sera for various cells such as blood corpuscles, and nerve cells. If they can produce such sera that will destroy normal cells, there is reason to hope that some day abnormal cells, or tumors may be attacked, and the cure of malignant tumors is a problem of the future.

I hope in a measure that I have been able to follow "the increasing purpose" and even indicate the rich promise of the future.

But what will discover this store-house of unknown treasures for you? What is its open sesame? The one word "service." I know of no life which typifies a service to mankind more than that of a physician, but I shall not attempt to further express this idea. This is so well expressed in a poem by Leigh Hunt, that I have often thought it should be the doctor's professional hymn. It is called "Abou Ben Adhem," and as it is very short I shall repeat it.

ABOU BEN ADHEM.

Abou Ben Adhem (may his tribes increase!)
Awoke one night from a deep dream of peace,
And saw within the moonlight of his room,
Making it rich, and like a lily in bloom
An angel, writing in a book of gold.
Exceeding peace had made Ben Adhem bold,
And to the presence in the room he said,
"What writest thou?" The vision raised its head,
And, with a look made all of sweet accord,
Answered, "The names of those who love the Lord!"
"And is mine one?" said Abou. "Nay, not so,"
Replied the angel. Abou spoke more low,
But cheerly still, and said "I pray thee then,
Write me as one who loves his fellow-men."
The angel wrote and vanished. The next night
It came again, with a great wakening light,
And showed the names whom love of God had blest;
And lo! Ben Adhem's name led all the rest.

Adherence to such principles will usually bring its own reward in a successful career, but at times the world may cry—Failure! Yet at least, as the twilight falls you will be comforted by the words of St. Paul.

"I have fought a good fight, I have finished my course, I have kept the faith."

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 THE TUBERCULOUS FAUCIAL TONSIL.

BY DR. GILLIFORD B. SWEENEY, '86, PITTSBURG, PA.,

Formerly of the Pasteur Institute, Paris.

The broadminded manner in which the profession has come to regard the tuberculous state as an entity, rather than a morbid condition, characterized by well defined symptoms, has unfortunately led us, during the past year or two, to neglect our study of specific etiological factors, which play an important part in the causation of this most formidable disease. It is for the purpose of considering the rôle of the tuberculous faucial tonsil that I revert to a subject which it was my privilege to discuss ten years ago, before the department of Laryngology and Rhinology of the American Medical Association, then convening at Denver, Colorado.

It is with temerity that I appear before this learned body to discuss a subject upon which much light has been shed by able members of the profession since I called attention to this important route of infection. Whether considered from an anatomical or physiological standpoint we must recognize the tonsil as presenting a most formidable route for systematic infection, particularly of a tuberculous nature. Its circulatory relationship to other organs is no more important than the position which it sustains towards respiration and deglutition.

Whether regarded as a focus for initial infection or a hotbed for propagating the poison which has entered the organism by some other route, the question loses none of its importance. Without any obviously good reason the impression prevailed for a number of years that primary tuberculosis of the tonsil is very rare. It remained for investigators such as Dieulafoy, Lartigan, Nicoll, and Harbitz to disabuse the minds of the profession upon the subject.

The statistics of primary tuberculosis, cervical adenitis or pronounced "Scrofula," have hitherto been taken as a fair index of the frequency of

infection through the upper air passages, more particularly the tonsils, but the proportion is far below that of supposedly primary disease of the bronchial nodes. Submaxillary and cervical nodes are so frequently enlarged in children from pyogenic infection that the decision as to the frequency of primary tuberculous infection of this lymph system is by no means easy.

A noteworthy contribution upon this subject has recently been furnished by Dr. Bandillier (*Beitraege zur Klinik der Tuberkulose*, VI. 1; *Berliner klinische Wochenschrift*, January 28), who, jointly with Paul Grawitz, of Greifswald, has studied microscopically a great number of exercised tuberculous tonsils. He concluded that tonsillar tuberculous disease develops on the basis of a chronic inflammation and is to be diagnosticated only microscopically. In cases of primary tuberculous disease it is a frequent accompaniment, generally as a secondary result of infection from sputum. However, primary tuberculous disease of the tonsils occurs from the inspiration and the ingestion of tubercle bacilli, and is not so very rare as is generally assumed.

Woods' (*Journal of the American Medical Association*, May, 6, 1905, p. 1425) laboratory experiments demonstrated that under certain conditions the apparently healthy state of the tonsils did not prevent the passage of virulent bacilli, through their substance, thence into the efferent lymph vessels.

On November 28, 1904, a small white hog was inoculated with virulent tubercle bacilli, by rubbing over the surface of the faucial tonsils a cotton swabbing, which was saturated with culture. The animal was killed on December 2, 1904. Post-mortem examination revealed no enlargement of the lymph glands, and the viscera were microscopically normal. Under strictly aseptic precautions the tonsillar lymph glands were removed from both sides of the neck, ground into a mortar with sterilized water and injected into the peritoneal cavity of two guinea-pigs. One died December 30, 1904, of general septicæmia, and the other was killed March 9, 1905. There was enlargement of the cervical and mesenteric lymph glands, enlargement and caseation of the bronchial glands. The liver was large, friable and dotted with tubercles. The spleen was greatly enlarged and infiltrated with numerous granules in which tubercle bacilli were found.

Goodale (*Journal of the American Medical Association*, November 24, 1906, p. 1731) cites seven cases of tuberculous cervical adenitis in which he removed the tonsils. Clinical inspection showed very little that was abnormal, but microscopical examination revealed tubercle and giant cells. With this tonsillar tissue he inoculated four guinea-pigs which afterwards died of tuberculosis. Cultures from the pigs proved that they had died of bovine tuberculosis.

A large proportion of the patients with tuberculous glands of the neck afterwards have pulmonary tuberculosis unless operated upon, but Grober's (*Klinische Jahrbuch*, 1905) statistics show that when the operation is performed it develops in only 14.3 per cent of the cases. Of his series of 760 adenoid removals, without regard to symptoms, tubercle bacilli were found in 6 per cent. The bacilli bore no relationship to the adenoids; they simply came in contact with the pharynx and remained there. Robertson (*Journal of the American Medical Association*, November 24, 1906) in 232 tonsillectomies, found 8 per cent tuberculous.

Bandelier (*Beiträge zur Klinik der Tuberkulose*, VI. 1) summarizes the principal communications previously published, and gives details of 100 cases in which the tonsils were found enlarged and tuberculous, among 900 tuberculous inmates of the Cottbus sanitarium. Tubercles were found in some of the tonsils, when on the surface they were apparently sound.

Jonathan Wright (*New York Journal*, January 6, 1906) is convinced from his carmin stained sections that dust, under ordinary conditions, passes readily through the intact epithelium of the tonsil. He acknowledges that this is a marked contrast to the way bacteria usually enter, yet clinical and microscopical evidence proves that pathogenic bacteria are absorbed through tonsillar epithelium.

It is beyond the scope of this paper to even briefly review the mass of data now available, which proves the faucial tonsil to be a potent factor in tuberculosis. Of more practical importance is the question of dealing successfully with the morbid condition as found in this organ. Aside from affording relief from acute disturbances, there is but one sure way to treat the unhealthy tonsil, and that is to remove it. I need not review the various methods employed successfully for its extirpation, but complete removal must be the object and end of such operation. For my own part,

I prefer a slightly modified Matthieus' tonsillatome, very rarely finding it necessary to trim the remaining stump with a punch or cautery curette.

As regards constitutional treatment but little need be said other than that which applies to any case of tuberculosis. Without wishing to seem captious I pause for a moment to ask, what actual advancement has been made during the past five years in the treatment of tuberculosis? Open air, forced feeding and rest form the triumvirate of potential agencies upon which the profession is chiefly depending at the present time, for relief from this scourge, which selects for its victim every seventh person in our country. The pendulum has swung and having swung are we to learn, within the next decade, that in the treatment of tuberculosis, as in many other social problems, one extreme is destined to follow upon the heels of another? Let us neither under-estimate nor over-value the virtues of pure air, sunshine, nutritious food and rest.

These measures are only the necessary and elementary conditions of hygienic living, indispensable for well and sick alike. They are not remedies in any true sense, and urging them with clamor and insistence is a virtual admission that the best that medical science can do to-day for a tuberculous patient is to place him in as favorable a situation as possible for his single-handed and unequal struggle with his formidable disease, and then leave him to his fate. It is true that a certain number of these patients recover, at least temporarily, but the issue in every instance depends in the last analysis upon the combative power of the individual patient.

When we consider the insidious manner in which the tubercle bacillus attacks its host, patiently awaiting in a quiescent state for a favorable opportunity to assume the aggressive, often seeming to completely succumb to climatic and nutritional influences while still easily discoverable in one or more of the secretions of the body, we realize that we have indeed a wary foe with which to deal. For my own part, I have but little confidence in any remedy or system of treatment which does not exert a specific influence upon the tubercle bacillus. Without wishing to make any extravagant claims for original work along this line, I beg to briefly refer to the efforts put forth by Dr. Edw. T. Smith and myself, having for their object the immunization of the human subject through the use of a serum prepared for that specific purpose.

The signal success achieved by Professor von Behring, in rendering young bovine cattle immune to tuberculosis and his even more brilliant achievement in transmitting this acquired immunity to other cattle, led Dr. Smith and myself to undertake a series of experiments having for their object the immunization of the tuberculous human subject. The results of our work have already been published in my monograph (*Animal Therapy, its Relation to Immunity, in the Treatment of Tuberculosis*) upon the subject, and subsequent reports have appeared in leading medical journals (*New York Medical Journal*, December 7, 1907, and March 28, 1908, et al.).

I do not wish to reflect discredit upon the excellent institutional and individual work which is being done at the present time for the tuberculous patient. Vast strides have been made in the way of relieving local manifestations of the malady, but as scientific men we must not overlook the essential question, which is one of *ultimate* results. Tuberculosis is not an aggressive disease. While it claims an enormous number of people for its victims it has its subjects offered to it. But while not aggressive in its disposition, tuberculosis has great persistency, and a tendency towards recurrence, hence the difficulty in judging the ultimate results of any treatment in a patient who has not been under the care of a given physician for a number of years at least.

In the world encircling movement, which is now on against the great white plague, an immense amount of benefit must be conferred upon humanity, even if its radical extermination were not accomplished. Yet in the East the light is breaking, and already we feel ourselves in the presence of a new day.

REVIEW IN SURGERY.

By ALEXIUS McGLANNAN, '05, BALTIMORE.

CRANIAL SURGERY.

Trephining the skull for injury is one of the most ancient of surgical operations. In the earliest times the operation was performed for the relief of compound and depressed fractures only, but the study of cerebral localization gave an immense impetus to cranial surgery, and so we find now the indication for operation extending to embrace hemorrhage, tumors and other lesions inside the skull. Still later the study of the circulation

in the brain and intercranial pressure has given us definite knowledge concerning the effects of increased tension and methods for its relief.

Fracture of the Skull.—By far the greatest number of operations on the skull are for the relief of conditions brought about by injury to the brain and its coverings. Charles Phelps (*Annals of Surgery*, April and May, 1909) is publishing an analytical and statistical review of 1000 cases of head injury. In this series he has observed 570 fractures of the base, 213 of the vault and 217 cases of injury without demonstrable fracture. The best part of the first paper is that dealing with the diagnosis of fracture of the skull. Phelps makes it a point to distinguish the symptoms of fracture from those of the intercranial injury that so often go with it.

The direct symptoms, especially in fracture of the vault, usually are easily made out by inspection and palpation, although once in a while an exploration becomes necessary. In the absence of symptoms of intercranial injury, a fracture of the vault becomes immaterial and no exploration should be made.

Hemorrhage is the most important symptom of basal fracture. It may be either intra or extra cranial, but is the one symptom upon which we may depend in the vast majority of cases. The blood may flow from the ear, the nose or the mouth, or it may collect as a hematoma in different parts of the head. Hemorrhage from the ear occurs most frequently (285 times in 405 of Phelps' cases), and is the most important of all. If it is clearly shown that the blood comes through the drum and has not flowed into the ear from an external wound, this sign may be considered pathognomonic of a petrous fracture involving the internal auditory canal.

Nasal hemorrhage becomes important only when a slow oozing from the nose begins about 24 hours after the injury. Profuse bleeding from the nose just after the injury is due so frequently to the local contusion that the symptom becomes valueless as a sign of fracture. The same is true of subconjunctival hemorrhage, coming on several hours after injury, it means a fracture of some part of the wall of the orbit.

Nasal or oral hemorrhage, in the absence of local lesions, and when there is no history of injury to the face, suggests fracture through the anterior or middle fossa.

Hematemesis following head injury is a possible result of fracture into the pharynx.

Subcutaneous hematoma is most important when it is found in the mastoid region. The examination must exclude blood that has gravitated from a temporal or temporo-parietal hematoma. With this possibility excluded, a mastoid hematoma is a certain indication of a fracture of a base of the skull. When ecchymosis is a primary symptom, and especially if the collection of blood has extended into the neck, mastoid hematoma indicates a fracture traversing an inferior occipital fossa. Ecchymosis appearing in this region on the second to the sixth day is probably due to petrous fracture extending into the mastoid process.

In addition to hemorrhage, Phelps notes as symptoms of basal fracture serous discharge, extrusion of brain tissue, implication of cranial nerves, localized pain. The last of these four may become quite important in the absence of other signs of fracture. It may be the only direct symptom of a fracture in the occipital fossa, and is then situated in the occipital region or over the mastoid process.

Treatment of Fracture of the Skull.—The importance of these fractures comes from the secondary effects of their existence. The bone fragments are not likely to be widely separated, unless the fracture is comminuted or compound, and firm union occurs rapidly. Depression of fragments causes pressure on the brain, and hemorrhage is important for the same reason.

Fracture of the vault requires no treatment unless there is a distinct open fissure. Then the skull should be trephined, because comminution or depression of the inner table is very probable.

The patient should be put at rest, given a sedative, if the headache is severe, and the bowels should be moved by salines.

Depressed fragments always require elevation. The fragments of a comminuted fracture should be elevated if they are depressed, and only pieces of bone without good dural or periosteal attachment should be removed.

Fractures of the base of the skull usually communicate with some of the openings of the head, in this way opening a route for infection of the meninges. Crowe (*Johns Hopkins Bulletin*, 1906) has shown that urotropin occurs in the cerebro-spinal fluid after its ingestion by the mouth. This drug, therefore, should be given in all cases of basal fracture.

As a further preventive of infection, the nose, mouth and ears may be

disinfected. Great care must be exercised here. It is probably best to simply wipe out the cavities with sterile swabs wet with a mild antiseptic solution.

Operation in fracture of the base is done for the relief of tension, occasionally in the hope of controlling hemorrhage. In the great majority of cases the fracture involves the middle fossa, and, therefore, Cushing ("Keen's Surgery," Vol. III, p. 89) recommends the intermusculo-temporal opening of the skull when operating on these patients. In cases where the signs point to an occipital fracture, the suboccipital opening should be made.

Hyperalgesia and Hyperesthesia after injury to the skull.—Vorschutz (*Deutsch. Zeit. f. Chirurg.*, LXXXVIII) publishes a valuable article on this subject, showing the frequent occurrence of hyperalgesic and hyperesthetic zones in various parts of the head and neck after injury to the skull or meninges. The work is really an extension of Head's investigations on the relation of superficial hyperesthetic areas to visceral disease. The fact that such areas occur after head injuries is of great practical importance, especially in medico-legal cases. The recognition of hyperalgesia will prevent our mistaking a true sufferer from a malingerer, but the converse is not positive, because these zones are not constant occurrences.

Concussion, Contusion and Compression.—The pathological and clinical relation of these conditions is so close that they are usually considered together. Whether this relation has an actual existence is a subject of controversy. Pathologists and clinicians are divided into two groups, those following von Bergmann, who taught that concussion could exist without contusion, and those who believe with Kocher, that in all cases of concussion there exist minute contusions scattered throughout the brain. If we follow the latter teaching, then these conditions become a sequence of changes increasing in severity as we pass from concussion to contusion and into the state of compression of the brain. The sequence of increasing severity of symptoms is often seen in the clinical course of a patient suffering from a head injury.

Concussion.—The essential symptoms of concussion is a loss of consciousness that may be momentary, or longer. This may be followed by simple lethargy or a condition resembling the sleep of drunkenness. With the restoration of consciousness there is usually headache, vertigo, nausea

and other general signs of cerebral disturbance. There is confusion or loss of memory concerning events incident to the injury. In many cases the patient becomes irritable, and even violent.

Contusion.—Like compression, this is always the result of injury. The degree of laceration varies in wide limits, from a minute extravasation to an extensive laceration. Frequently the contusion is associated with a bursting fracture of the skull. The symptoms of contusion are practically an intensification of those of concussion. The period of unconsciousness is usually longer and signs of compression almost always appear. When they do occur, lumbar puncture will as a rule draw off bloody fluid.

Compression.—In addition to injury, intercranial tumors, abscess, etc., give rise to compression of the brain. As a rule the latter causes give a less acute compression than the former.

Compression the result of injury may be due to hemorrhage or to cerebral edema from contusions. This edema (serous amicrobic meningitis) is a frequent cause of compression following injury to the head which does not produce fracture of the skull.

The danger point in compression is the medulla; a very little pressure here will cause rapidly fatal anemia of the vital centers, while a much greater local pressure in the frontal or temporal region may be practically without symptoms.

Kocher, Cushing, Cannon and others have shown experimentally that there is provided a marvelous protection to the medulla by means of the arrangement of cerebral membranes, and the circulation of the cerebro-spinal fluid, as well as the blood in the skull.

The blood-vascular symptoms of compression are evidences of the local and general variations in blood pressure, progressively brought forth to protect the medulla, or are due to the failure of this compensation.

Kocher ("Nothnagel's *Specielle Path. und Therapie*," 1901) has divided the effects of increased tension into four stages, representing progressive increase of tension. Clinically, it is common to have the symptoms bridge these stages. Occasionally the process is arrested at one or the other stage, or it may pass directly on to the last almost immediately, depending on the severity of the lesion. The stages of general increased tension, as described by Kocher, are:

1. The stage of compensation in which the escape of cerebro-spinal

fluid and the narrowing of the veins makes the disturbance slight and without severe symptoms.

2. Failing local compensation. Here the pressure is sufficient to lessen the amount of blood flowing throughout a considerable part of the capillary field, but without serious alteration in the nutrition of the vital centers.

3. General circulatory involvement. Here the tension is sufficient to involve the medulla and call forth the general vasomotor regulation for compensatory action.

4. Failing general compensation.

The symptoms of compression vary with the stages and progress in a like manner. Serious cases pass rapidly on to the late stages. At first the symptoms may be mild and insignificant. Headache is practically always present, and with it there may be some mental dulness. Later, in progressive cases, or early in the more serious injuries, in addition to pronounced headache we note vertigo, restlessness, excitement or delirium. Now certain objective symptoms become apparent. Of these the rise in blood pressure and the state of the eye grounds are most important. The ophthalmoscope reveals dilation of the veins, which are also tortuous, and often a beginning edema of the nerve. The external veins of the head, especially the venules of the eyelids, are dilated and the face is usually cyanosed.

In the third stage there is a marked rise in blood pressure; the respiration approaches the Cheyne-Stokes type; the pulse is slowed to 40-50 per minute and is bounding in character, of the vagal quality. Examination of the retina shows choked disk. As the fourth stage is approached there is a gradual failure of the compensatory action of the general circulation, the blood pressure falls, the pulse become rapid, the heart's action and the respiratory movements become irregular and the patient passes into coma and dies from respiratory paralysis.

Of the objective symptoms, the condition of the eye grounds is probably the most important. The regularity of this symptom has caused a great deal of discussion. Much of this, I feel sure, is due to misunderstanding by the ophthalmologists of what the condition of the retina is in early compression. Cushing ("Keen's Surgery," Vol. IV, p. 161) points out that we must not expect to find a full-blown choked disk, but must look for slight edema, with distension and tortuosity of the veins. Frazier

(*Journal American Medical Association*, June 5, 1909) quotes de Schweinitz as to the rarity of papilledema in head injury, and doubts its value in diagnosis. Probably he is one of the observers who has overlooked Cushing's advice quoted above.

The effect on the optic nerve of mechanical increase of intracranial pressure has been studied experimentally by Cushing and Bordley (*Journal American Medical Association*, January 20, 1909). They show how an increasing pressure persistently produced brings out greater venous dilation and edema, which finally causes structural change. The formation of new connective tissue is characteristic of chronic passive congestion everywhere. From the results of these experiments it seems that choked disk is a better name for the condition than optic neuritis, papillitis, etc., names indicating an inflammatory origin of the lesion.

Treatment.—Seeking the cure of the results of cerebral trauma, we disregard the terms concussion and contusion and their significance, considering only the symptoms as they indicate degrees of cerebral compression. As long as the symptoms indicate the first, or early second stage, of compression, when the local compensation seems able to take care of the lesion, non-operative measures are indicated. The patient should be put to bed immediately with an ice cap on the head. Often it is well to shave off the hair. Atropin doses of 1/200 gr. is said to be valuable. If the patient is shocked, salt solution by the rectum or subcutaneously, with bandaging of the extremities and pressure over the abdomen, should be used.

If the symptoms persist for more than a few hours, or seem to be passing on to those of a more severe compression, a lumbar puncture will give valuable aid. An extravasation of blood will be indicated by bloody fluid from the puncture, while clear fluid shows that the pressure is due to edema. Persistence of pressure symptoms after lumbar puncture is an indication for the decompression operation.

Whenever the initial symptoms have been severe or persistent, the patient must be kept in bed from 10 to 14 days. An ice bag should be used continuously, the bowels moved daily, and the diet restricted.

When the signs of compression indicate the third stage, then the decompression operation is indicated. By means of this procedure we are able to relieve the failing compensation, and when the intermusculo-temporal route, devised by Cushing is used, to control the cause in many cases.

In reporting a case of subdural hemorrhage (*Military Surgeon*, December, 1908), I described the method of performing this operation, giving references to the original papers.

Intercranial Hemorrhage of the Newborn.—The recognition of this condition is of the utmost importance, because operation at the proper time will save the life and intellect of these children, as well as prevent development of various paralyses. Hemorrhage is usually subdural, very rarely in the brain itself, or in the ventricles.

The clinical picture is quite definite and varies as the seat of the hemorrhage is pretentorial or subtentorial.

The symptoms are those of acute compression, and, as is to be expected, are much more serious in the subtentorial hemorrhages.

Pretentorial hemorrhage is usually unilateral, the clot may be quite large, with relatively few signs of general compression. The first symptom noticed is the extreme restlessness of the child, usually beginning about 48 hours after birth. When this restlessness is accompanied by ceaseless screaming, without apparent cause, it is practically pathognomonic. Later the general symptoms of increased intercranial tension appear. If unrelieved death follows from anemia of the medulla.

Subtentorial hemorrhage is much more serious than the foregoing. The child is usually born asphyxiated, but for the first few hours seems healthy and is quiet. Very soon, however, symptoms of the fourth stage of compression appear and death follows in from 36 to 48 hours.

Whenever these cases are seen early enough a decompression operation should be done, either temporal or occipital, according to the location of the clot.

Seitz (*Munch. Klin. Woch.*, March 24, 1908) is quoted by Frazier (*Progressive Medicine*, March, 1909) on this subject. His statistics are based on 23 cases, 18 of which were fatal, but only one of these had been operated on. The five recoveries followed operation, proving, therefore, that surgery offers the only chance for cure.

Tumors.—Almost every known variety of tumor has been found in the brain. The infectious granulomata are by far the most commonly recorded type (Cushing. Keen's Surgery).

Tuberculoma is most common in the cerebellum, and especially frequent

in children. They may be solitary, but are usually multiple and vary greatly in size.

Syphiloma is more common in adults, is often multiple and may reach a great size.

The cerebral granulomata are particularly fibrous; the tuberculoma usually has a firm fibrous capsule, while the gumma is very dense and resistant to antiluetic medicines. On account of this fibrosis both forms require excision for cure. The gumma is usually superficial and accessible. The tuberculoma may be deep and may lead to tuberculous meningitis.

Endothelioma (probably fibro-sarcoma).—These tumors are relatively benign growths that spring from the meninges and produce symptoms by pressure on, rather than by infiltration of the brain itself. Their most common seat is the cerebello-pontine recess.

Glioma.—These are soft infiltrating tumors originating from the neuroglia. They become very large and may undergo central cystic degeneration. Because of their great vascularity hemorrhage is frequent in the course of these tumors and may be the first symptom of their pressure. An apoplexy in a young individual without arterio-sclerosis should lead to a search for a glioma.

Cysts are very important tumors of the brain. Certain cysts are the results of injury; others are due to parasites, and occasionally they come from degeneration of a glioma. Porencephalic cysts are most likely the result of hemorrhage. These cysts cause irritative or paralytic symptoms, while the traumatic and parasitic varieties cause pressure symptoms.

Carcinoma is metastatic, usually in the bones of the skull, and invades the brain in its growth.

Sarcoma may be primary in the cranial bones, or may be metastatic.

Teratoma are also found, their most common situation being the pituitary body and the mid-basal region.

The signs of brain tumor are both general and localized. Of the former there are four cardinal symptoms—headache, nausea, vomiting and choked disk. These are pressure symptoms, and the absence of any of the circulatory-respiratory signs so prominent in acute compression is due to the gradual increase of pressure in cases of tumor and the action of the compensatory apparatus.

Any or all of these cardinal symptoms may be absent during the entire course of a brain tumor. As a rule, however, one or more of them is present at some time, but their absence is not proof that no tumor is present. The headache is the most constant symptom, in many cases the only one until late in the disease. Infiltrating tumors and abscesses located in silent areas are very likely to give no general symptoms.

These four cardinal symptoms may be present without any localizing signs, and bear no relation to the size, situation or nature of the tumor.

Headache is usually diffuse and dull, and may occur only in the morning hours. The situation varies and is of no localizing value unless the pain is constantly referred to one spot which is found to be tender. Under such circumstances it is probable that the tumor is pressing against the skull at this particular point.

Vomiting is an irregular symptom. It may occur at intervals, with or without nausea and irrespective of food. It is often projectile and may be limited to the morning. Position frequently is a controlling factor.

Choked disk is the most reliable symptom. Nephritis is the only disease in which this condition and the other symptoms are likely to lead to confusion. A unilateral choke is a probable indication of a tumor situated on the same side of the brain near the orbit, but variation in the degree of pressure shown in either eye cannot be considered of value in localization.

Localizing symptoms when present indicate the position of the tumor in the brain. The interpretation of these symptoms depends on the study of cerebral localization. This subject is so extensive that we shall take it up in a special review.

Hydrocephalus.—The many methods devised for the surgical treatment of this condition have not yet made its cure a surgical triumph. Meningitis due to ascending infection through the drainage channels has been the end result in all attempts to drain the ventricles to the surface of the body. Of the many newer methods, that of Payr (*Archiv. f. Klin. Chir.*, LXXXVII) seems most likely to give good results. He drains the lateral ventricle into the superior longitudinal sinus by means of the transplantation of a piece of blood vessel, making an anastomosis at one end with the sinus, and at the other with the lining of the ventricle.

Epilepsy.—Nearly 20 years ago Kocher published his opinion that epilepsy is due to increased intracranial tension and that the proper treatment is by decompressive operation. Since that time many controversies have been waged on the subject, but now we find the matter is about in the state he left it after Frankel's opposition in 1905. The establishment of a permanent opening in the skull seems to be the operation that gives greatest and most persistent relief to the greatest number of epileptics. If we add Krause's excision of the cortical center, the involvement of which is indicated by the symptoms, we have probably reached the limit of operation justified by our present knowledge of this disease.

Plastic repair of bone defects of the skull has attracted much attention. The value of such operations in epilepsy is doubtful; certainly such a procedure antagonizes Kocher's conclusions. Of the various methods devised, that of Dudley P. Allen (*Boston Medical and Surgical Journal*, April 12, 1906) seems most practicable. Briefly the method consists in transplanting into the defect an area of periosteum with an attached thin slice of bone from the outer table of the skull. The growth of the graft is proved by histological studies of a series of experiments on dogs.

Abscess.—The etiology of brain abscesses may be trauma, pyemia, or extension from ear suppuration. The route of extension or infection may be lymphatic or circulatory.

The symptoms are often indefinite, and many cases go unrecognized until the terminal stage is reached, or even post-mortem. The acute abscess may go unrecognized and the resulting chronic abscess may persist for many years without general symptoms. Such a chronic abscess of the frontal lobe may give rise to mental symptoms and the patient be treated for years in an asylum as a sufferer from a psychosis. The general symptoms are usually divided into four stages. (a) Initial stage, where the signs are those of acute septic infection. (b) Latent; these initial symptoms subside, but do not entirely disappear. There is headache and nausea, possibly chilliness and fever. (c) Manifest. The headache becomes severe and there is vomiting. Usually there is leucocytosis; the temperature becomes subnormal; drowsiness, irritability and slowing of the pulse are present. The bone over the seat of the abscess is usually tender. (d) Terminal. The temperature becoming high and the patient dies with symptoms of the last stage of compression.

Localization of an abscess is a most difficult procedure. Probably the only rule to follow is to operate at the seat of the supposed external cause. The diagnosis is difficult, especially in the cases following ear disease. In operating, if an extensive serous meningitis is discovered, it is wise to wait until the effects of the decompression are observed before going into the brain tissue in search for an abscess.

AFTER ALL.

You're the butt of many a joke,
Doctor-man;
We hand you many a poke,
Doctor-man;
But when we're feeling ill
We're not satisfied until
We've partaken of your pill,
Doctor-man.

That your ignorance is great,
Doctor-man,
We very freely state,
Doctor-man.
But when the microbes on us land,
And the germs have us unmanned,
We'd have you close at hand,
Doctor-man.

We meet your bill with squalls,
Doctor-man;
Charge you with needless calls,
Doctor-man;
But if baby's taken sick,
Or Marjorie or Dick,
We forget it mighty quick,
Doctor-man.

So, in spite of all our slams,
Doctor-man.
And our funny epigrams,
Doctor-man.
And though frequently we doubt you,
And say mean things about you,
We can hardly do without you,
Doctor-man.

—*Toledo Blade.*

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THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE PHARMACOPEAL CONVENTION.

The next Pharmacopeal Convention will be held in Washington next May. This Convention is made up of delegates from the incorporated medical colleges, the medical schools connected with incorporated medical colleges and universities, incorporated colleges of pharmacy and pharmaceutical schools connected with incorporated universities, incorporated state medical associations, pharmaceutical associations, the American Medical Association, the American Pharmaceutical Association, the American Chemical Society, as well as delegates from the Army, Navy and Marine Hospital Service. Each of the above being entitled to send three delegates.

The revision of the Pharmacopea is a very important matter and one physicians would do well to interest themselves in. There is great diversity of opinion regarding just what the Pharmacopea should be, the teachers in medical schools wanting one thing and the pharmacists another, whilst a great many physicians have no decided opinions upon the matter.

The Pharmacopea should primarily be for the medical profession and should contain only the best drugs in use throughout the world and the best preparations of these drugs, and an effort should be made to bring about a certain degree of uniformity in the different pharmacopeas throughout the world. This would simplify the teaching of medicine

very greatly, and it would make examinations both in school and by State boards more fair than they are at present. The present collection of drugs and preparations in the Pharmacopea is so large that it would be impossible and undesirable for any one to be acquainted with every drug and every preparation.

The manufacturers and pharmacists, however, wish to have the Pharmacopea as a legal standard for all kinds of chemicals, flavoring agents and what not, quite irrespective of their use by physicians. Whilst it is highly desirable that there should be legal standards for such things the Pharmacopea does not seem to be the proper place. The Pharmacopea should be reduced in size so that it would correspond to those of England and Germany, by taking out all drugs and preparations which are not thought to be of sufficient value to be retained and placing these in the National Formulary, and legal standards for chemicals, etc., could also be placed in the National Formulary, or if thought desirable a separate book of National Standards could easily be established. One has only to look over the Pharmacopea to see the number of obsolete drugs and preparation which the medical student must perforce learn, and if one looks over the examination questions of the State board they find that many examiners ask questions about drugs which are rarely, if ever, used. All the drugs in the Pharmacopea should be those about which there is no question as to their value. If there is any question the drug should be relegated to the National Formulary. With such a list it would then be possible to require the medical student to have a good and sufficient knowledge of each preparation and each drug, and the work of both teacher and student would be simplified.

A NEW DEPARTURE IN LIFE INSURANCE.

Some of the life insurance companies have come to the conclusion that it will be cheaper to keep in touch with their policyholders, to have them looked over occasionally to detect, if possible, any signs of wear or tear and to take the necessary preventive measures to arrest any beginning disease. The Provident Savings Life Assurance Society has established a policyholder's health bureau by which they expect to reach the policy-

holders in three ways. First, by bulletins issued from time to time giving the more important points about the prevention of disease and the promotion of health. Secondly, by correspondence where the policyholder can, free of cost, secure any information that he wants regarding these questions and thirdly, each policyholder will be entitled to a free medical examination each year if the necessary application for the same is filed. The examination is to be made by the medical examiner and the company will pay him a small fee for making the examination. The fee is too small and, at the present scope of the examination, it would seem to be too limited to be of the greatest possible value. The fee as now contemplated does not cover an examination of the urine which is, from an insurance standpoint as well as that of health, a most important procedure.

The first bulletin contained some very good advice with reference to avoiding the degenerative diseases and called attention to points in regard to eating, drinking and exercise and also some hints for hot weather, the bulletin having appeared in July. The second bulletin, issued in November, deals with pneumonia and various diseases of the nose, throat and chest, and what to do to avoid them, and it also takes up the question of typhoid fever and of hook-worm disease. The bulletin calls attention to the spread of typhoid by railroads, a point which, up to this time, has received but scant attention. It would seem that it is time that the transportation officials would devise some means of destroying the sewage from railway trains.

This plan of using the doctor as a means of preventing disease is an important one and the value of the physician's advice in such matters is being recognized more and more in this country. It is to be hoped that the physicians will take an interest in this matter and that they will also protect their own interests in seeing that they are paid a sufficient amount for the time and trouble which this will involve. Patients, insurance companies and others seem to think that advice given to people in health is free. It is largely the doctors' own fault, as most of us become so accustomed to giving so much advice to people unable to pay for it, and very properly so, that we forget that those who are able to pay for it should be made to do so.

Obituary.

DR. JACOB HAMAKER DRAWBAUGH, '86, a member of the American Medical Association, died at his home in Shiremanstown, Pa., September 4, from tuberculosis, aged 50.

DR. BENJAMIN ROBERT BRYANT, '81, for two terms a representative in the House of Delegates from Southampton County, Va., died at his home in Boykins, November 14, from pernicious anemia, aged 51.

DR. MIKHAIL FARAG, '07, died in Tanta, Egypt. Dr. Farag was one of the best known and one of the most popular of the young Egyptians that we have ever had about the College. He will be mourned by a large number of friends who had learned to love him.

DR. JOHN HARVEY DAVISSON, '76, and Cathell gold medalist of his class, a member of the American Medical Association, one of the organizers of the Southern California Medical Society and of the California Hospital Association, formerly president of the California State Board of Health, for four terms a member of the Los Angeles Board of Health, formerly professor of physiology and materia medica in the Fort Wayne (Ind.) College of Medicine, local surgeon at Warsaw to the Pennsylvania System, and secretary of the Surgeons' Association of the Pennsylvania Railway, died at his home in Los Angeles, November 1, from nephritis, aged 60.

Correspondence.

BURNSVILLE, W. VA., July 19, 1909.

CHAS. E. BRACK, M. D., 500 East 20th Street, Baltimore, Md.

Dear Doctor.—I intended to hand you \$1, to renew my subscription to THE JOURNAL, when I was in Baltimore attending the Alumni meeting, but I got so interested in "the boys," old and young, that I forgot it. I certainly had a time long to be remembered.

I enclose my check for one dollar. With best wishes and kindest regards,

Yours truly,

J. W. KIDD.

LITTLE ROCK, ARK., August 1, 1909.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Please find enclosed my check for \$2.00 and kindly mail the JOURNAL to my present address.

I have been in Little Rock for about 18 months now, and am doing nicely.

I have recently been made Professor of Nervous and Mental Diseases in the University of Arkansas Medical Department and am specializing along those lines with gratifying success.

Hope to be in Baltimore in the next twelve months and have the pleasure of seeing you then.

Very truly,

EDWIN P. BLEDSOE, '05.

CASTALIA, N. C., December 15, 1909.

DR. CHAS. E. BRACK, Baltimore, Md.

My Dear Dr. Brack.—A few copies of the ALUMNI JOURNAL have found their way to Castalia and I appreciate them very much.

I am very proud of "old P. & S." and love to hear how you all are getting along.

Am enclosing you one dollar, for which please send me the JOURNAL next year. Regards to all.

Yours truly,

THOMAS OLIVER COPPEDGE, '08.

WHEELING, W. VA., December 30, 1909.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find check for 1909 and 1910 subscriptions to the JOURNAL.

While at Louisville this summer attending the Shrine conclave I met Messinger, '02, the Canuk; he still insists on leading his high life and after indulging in some White Rock we "explored" Louisville in an automobile. He is doing a good practice in Birmingham, Ala.

I am always pleased to receive the JOURNAL and see what the boys are doing.

Wishing you and all the Alumni a happy and prosperous New Year, I am,

Yours fraternally,

G. L. VIEWEG, '02.

HUNTINGTON, WEST VA., December 16, 1909.

Dear Doctor Brack.—Enclosed please find check for two dollars, for my subscription to the JOURNAL. I would like to have the address of every member of the class of '08, for I want to keep track of them as far as possible.

With kindest regards, I am

Very truly yours,

J. H. STEENBERGEN.

Personal Notes.

DR. G. W. TYRRELL, '93, is practicing at Perth Amboy, New Jersey.

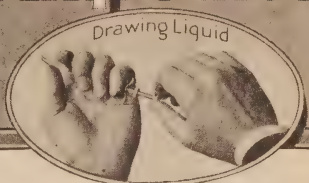
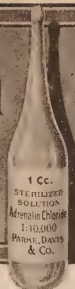
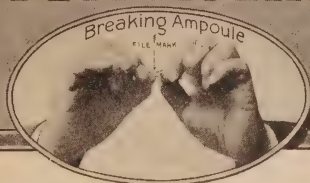
DR. T. G. HAMRICK, '95, who has been successful in practice in Caroleen, N. C., for fifteen years, will remove to Shelby, N. C., and open a private hospital.

DR. T. JUDD McBEE, '05, is located at Elkins, West Virginia, and is in charge of the State Home of the West Virginia Humane Society. He is also secretary of the Randolph-Tucker-Barber County Medical Society.

Many of the boys of ten or fifteen years ago will remember with pleasure JAMES A. TIERNEY, who served as pharmacist at the City Hospital and also at Bay View. He is now located at Glenville, West Virginia, where he is associated in business with his brother.

Trade is occupation for livelihood; profession is occupation for service of the world. Trade is occupation for joy in the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade is occupation often taken up temporarily, until something better offers; profession is occupation with which one is identified for life. Trade makes one the rival of every other trader; profession makes one the co-operator with all his colleagues. Trade knows only the ethics of success; profession is bound by lasting ties of sacred honor.—*President Faunce, Brown University.*

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